of heavy coffee consumption would be diagnosed as Caffeine-Induced Anxiety Disorder, With Generalized Anxiety.

When another Axis I disorder is present, an additional diagnosis of Generalized Anxiety Disorder should be made only when the focus of the anxiety and worry is unrelated to the other disorder, that is, the excessive worry is not restricted to having a Panic Attack (as in **Panic Disorder**), being embarrassed in public (as in **Social Phobia**), being contaminated (as in **Obsessive-Compulsive Disorder**), gaining weight (as in **Anorexia Nervosa**), having a serious illness (as in **Hypochondriasis**), having multiple physical complaints (as in **Somatization Disorder**), or to concerns about the welfare of close relations or being away from them or from home (as in **Separation Anxiety Disorder**). For example, the anxiety present in Social Phobia is focused on upcoming social situations in which the individual must perform or be evaluated by others, whereas individuals with Generalized Anxiety Disorder experience anxiety whether or not they are being evaluated.

Several features distinguish the excessive worry of Generalized Anxiety Disorder from the **obsessional thoughts** of Obsessive-Compulsive Disorder. Obsessional thoughts are not simply excessive worries about everyday or real-life problems, but rather are ego-dystonic intrusions that often take the form of urges, impulses, and images in addition to thoughts. Finally, most obsessions are accompanied by compulsions that reduce the anxiety associated with the obsessions.

Anxiety is invariably present in **Posttraumatic Stress Disorder.** Generalized Anxiety Disorder is not diagnosed if the anxiety occurs exclusively during the course of Posttraumatic Stress Disorder. Anxiety may also be present in **Adjustment Disorder,** but this residual category should be used only when the criteria are not met for any other Anxiety Disorder (including Generalized Anxiety Disorder). Moreover, in Adjustment Disorder the anxiety occurs in response to a life stressor and does not persist for more than 6 months after the termination of the stressor or its consequences. Generalized anxiety is a common associated feature of **Mood Disorders** and **Psychotic Disorders** and should not be diagnosed separately if it occurs exclusively during the course of these conditions.

Several features distinguish Generalized Anxiety Disorder from **nonpathological anxiety.** First, the worries associated with Generalized Anxiety Disorder are difficult to control and typically interfere significantly with functioning, whereas the worries of everyday life are perceived as more controllable and can be put off until later. Second, the worries associated with Generalized Anxiety Disorder are more pervasive, pronounced, distressing, and of longer duration and frequently occur without precipitants. The more life circumstances about which a person worries excessively (finances, children's safety, job performance, car repairs), the more likely the diagnosis. Third, everyday worries are much less likely to be accompanied by physical symptoms (e.g., excessive fatigue, restlessness, feeling keyed up or on edge, irritability), although this is less true of children.

Diagnostic criteria for 300.02 Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:** Only one item is required in children.

(1) restlessness or feeling keyed up or on edge
(2) being easily fatigued
(3) difficulty concentrating or mind going blank
(4) irritability
(5) muscle tension
(6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

293.84 Anxiety Disorder Due to a General Medical Condition

Diagnostic Features

The essential feature of Anxiety Disorder Due to a General Medical Condition is clinically significant anxiety that is judged to be due to the direct physiological effects of a general medical condition. Symptoms can include prominent, generalized anxiety symptoms, Panic Attacks, or obsessions or compulsions (Criterion A). There must be evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition (Cri-

terion B). The disturbance is not better accounted for by another mental disorder, such as Adjustment Disorder With Anxiety, in which the stressor is the general medical condition (Criterion C). The diagnosis is not made if the anxiety symptoms occur only during the course of a delirium (Criterion D). The anxiety symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E).

In determining whether the anxiety symptoms are due to a general medical condition, the clinician must first establish the presence of a general medical condition. Further, the clinician must establish that the anxiety symptoms are etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the anxiety symptoms and the general medical condition is etiological, several considerations provide some guidance in this area. One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and the anxiety symptoms. A second consideration is the presence of features that are atypical of a primary Anxiety Disorder (e.g., atypical age at onset or course, or absence of family history). Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of anxiety symptoms may provide a useful context in the assessment of a particular situation. In addition, the clinician must also judge that the disturbance is not better accounted for by a primary Anxiety Disorder, a Substance-Induced Anxiety Disorder, or other primary mental disorders (e.g., Adjustment Disorder). These determinations are explained in greater detail in the "Mental Disorders Due to a General Medical Condition" section (p. 181).

Specifiers

The following specifiers can be used to indicate which symptom presentation predominates in Anxiety Disorder Due to a General Medical Condition:

With Generalized Anxiety. This specifier may be used if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation.

With Panic Attacks. This specifier may be used if Panic Attacks (see p. 430) predominate in the clinical presentation.

With Obsessive-Compulsive Symptoms. This specifier may be used if obsessions or compulsions predominate in the clinical presentation.

Recording Procedures

In recording the diagnosis of Anxiety Disorder Due to a General Medical Condition, the clinician should first note the presence of the Anxiety Disorder, then the identified general medical condition judged to be causing the disturbance, and finally the appropriate specifier indicating the predominant symptom presentation on Axis I (e.g., 293.84 Anxiety Disorder Due to Thyrotoxicosis, With Generalized Anxiety). The ICD-9-CM code for the general medical condition should also be noted on Axis III (e.g., 242.9

thyrotoxicosis). See Appendix G for a list of ICD-9-CM diagnostic codes for selected general medical conditions.

Associated General Medical Conditions

A variety of general medical conditions may cause anxiety symptoms, including endocrine conditions (e.g., hyper- and hypothyroidism, pheochromocytoma, hypoglycemia, hyperadrenocorticism), cardiovascular conditions (e.g., congestive heart failure, pulmonary embolism, arrhythmia), respiratory conditions (e.g., chronic obstructive pulmonary disease, pneumonia, hyperventilation), metabolic conditions (e.g., vitamin B_{12} deficiency, porphyria), and neurological conditions (e.g., neoplasms, vestibular dysfunction, encephalitis). The associated physical examination findings, laboratory findings, and patterns of prevalence or onset reflect the etiological general medical condition.

Differential Diagnosis

A separate diagnosis of Anxiety Disorder Due to a General Medical Condition is not given if the anxiety disturbance occurs exclusively during the course of a **delirium.** However, a diagnosis of Anxiety Disorder Due to a General Medical Condition may be given in addition to a diagnosis of **dementia** if the anxiety is a direct etiological consequence of the pathological process causing the dementia and is a prominent part of the clinical presentation. If the presentation includes a mix of different types of symptoms (e.g., mood and anxiety), the specific Mental Disorder Due to a General Medical Condition depends on which symptoms predominate in the clinical picture.

If there is evidence of recent or prolonged substance use (including medications with psychoactive effects), withdrawal from a substance, or exposure to a toxin, a **Substance-Induced Anxiety Disorder** should be considered. It may be useful to obtain a urine or blood drug screen or other appropriate laboratory evaluation. Symptoms that occur during or shortly after (i.e., within 4 weeks of) Substance Intoxication or Withdrawal or after medication use may be especially indicative of a Substance-Induced Anxiety Disorder, depending on the type, duration, or amount of the substance used. If the clinician has ascertained that the disturbance is due to both a general medical condition and substance use, both diagnoses (i.e., Anxiety Disorder Due to a General Medical Condition and Substance-Induced Anxiety Disorder) can be given.

Anxiety Disorder Due to a General Medical Condition should be distinguished from a **primary Anxiety Disorder** (especially Panic Disorder, Generalized Anxiety Disorder, and Obsessive-Compulsive Disorder) and from **Adjustment Disorder With Anxiety** or **With Mixed Anxiety and Depressed Mood** (e.g., a maladaptive response to the stress of having a general medical condition). In primary mental disorders, no specific and direct causative physiological mechanisms associated with a general medical condition can be demonstrated. Late age at onset and the absence of a personal or family history of Anxiety Disorders suggest the need for a thorough assessment to rule out the diagnosis of Anxiety Disorder Due to a General Medical Condition. In addition, anxiety symptoms may be an **associated feature of another mental disorder** (e.g., Schizophrenia, Anorexia Nervosa).

Anxiety Disorder Not Otherwise Specified is diagnosed if the clinician cannot de-

termine whether the anxiety disturbance is primary, substance induced, or due to a general medical condition.

Diagnostic criteria for 293.84 Anxiety Disorder Due to . . . *[Indicate the General Medical Condition]*

A. Prominent anxiety, Panic Attacks, or obsessions or compulsions predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.

C. The disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder With Anxiety in which the stressor is a serious general medical condition).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With Generalized Anxiety: if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation
With Panic Attacks: if Panic Attacks (see p. 432) predominate in the clinical presentation
With Obsessive-Compulsive Symptoms: if obsessions or compulsions predominate in the clinical presentation

Coding note: Include the name of the general medical condition on Axis I, e.g., 293.84 Anxiety Disorder Due to Pheochromocytoma, With Generalized Anxiety; also code the general medical condition on Axis III (see Appendix G for codes).

Substance-Induced Anxiety Disorder

Diagnostic Features

The essential features of Substance-Induced Anxiety Disorder are prominent anxiety symptoms (Criterion A) that are judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure) (Criterion B). Depending on the nature of the substance and the context in which the symptoms occur (i.e., during intoxication or withdrawal), the disturbance may involve prominent anxiety, Panic Attacks, phobias, or obsessions or compulsions. Although the clinical presentation of the Substance-Induced Anxiety Disorder may resemble that of Panic Disorder, Generalized Anxiety Disorder, Social Phobia, or Obsessive-Compulsive Disorder, the full criteria for one of these disorders need not be met. The disturbance

must not be better accounted for by a mental disorder (e.g., another Anxiety Disorder) that is not substance induced (Criterion C). The diagnosis is not made if the anxiety symptoms occur only during the course of a delirium (Criterion D). The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E). This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the anxiety symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the anxiety symptoms are sufficiently severe to warrant independent clinical attention. For a more detailed discussion of Substance-Related Disorders, see p. 191.

A Substance-Induced Anxiety Disorder is distinguished from a primary Anxiety Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of Dependence, Abuse, intoxication, or withdrawal.

Substance-Induced Anxiety Disorders arise only in association with intoxication or withdrawal states, whereas primary Anxiety Disorders may precede the onset of substance use or occur during times of sustained abstinence. Because the withdrawal state for some substances (e.g., some benzodiazepines) can be relatively protracted, the onset of the anxiety symptoms can occur up to 4 weeks after cessation of substance use but is usually earlier.

Another consideration is the presence of features that are atypical of a primary Anxiety Disorder (e.g., atypical age at onset or course). For example, the onset of Panic Disorder after age 45 years (which is rare) or the presence of atypical symptoms during a Panic Attack (e.g., true vertigo; loss of balance, consciousness, or bladder or bowel control; headaches; slurred speech; or amnesia) may suggest a substance-induced etiology. In contrast, factors suggesting that the anxiety symptoms are better accounted for by a primary Anxiety Disorder include persistence of anxiety symptoms for a substantial period of time (i.e., a month or longer) after the end of Substance Intoxication or acute Withdrawal; the development of symptoms that are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or a history of prior recurrent primary Anxiety Disorders.

Specifiers

The following specifiers can be used to indicate which symptom presentation predominates:

With Generalized Anxiety. This specifier may be used if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation.

With Panic Attacks. This specifier may be used if Panic Attacks (see p. 430) predominate in the clinical presentation.

With Obsessive-Compulsive Symptoms. This specifier may be used if obsessions or compulsions predominate in the clinical presentation.

With Phobic Symptoms. This specifier may be used if phobic symptoms predominate in the clinical presentation.

The context of the development of the anxiety symptoms may be indicated by using one of the following specifiers:

With Onset During Intoxication. This specifier should be used if criteria for intoxication with the substance are met and the symptoms develop during the intoxication syndrome.

With Onset During Withdrawal. This specifier should be used if criteria for withdrawal from the substance are met and the symptoms develop during, or shortly after, a withdrawal syndrome.

Recording Procedures

The name of the diagnosis of Substance-Induced Anxiety Disorder begins with the specific substance (e.g., alcohol, methylphenidate, thyroxine) that is presumed to be causing the anxiety symptoms. The diagnostic code is selected from the listing of classes of substances provided in the criteria set. For substances that do not fit into any of the classes (e.g., thyroxine), the code for "Other Substance" should be used. In addition, for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code on Axis I (see Appendix G). The name of the disorder (e.g., Caffeine-Induced Anxiety Disorder) is followed by the specification of the predominant symptom presentation and the context in which the symptoms developed (e.g., 292.89 Caffeine-Induced Anxiety Disorder, With Panic Attacks, With Onset During Intoxication). When more than one substance is judged to play a significant role in the development of anxiety symptoms, each should be listed separately (e.g., 292.89 Cocaine-Induced Anxiety Disorder, With Generalized Anxiety, With Onset During Intoxication; 291.89 Alcohol-Induced Anxiety Disorder, With Generalized Anxiety, With Onset During Withdrawal). If a substance is judged to be the etiological factor, but the specific substance or class of substances is unknown, the category 292.89 Unknown Substance–Induced Anxiety Disorder should be used.

Specific Substances

Anxiety Disorders can occur in association with **intoxication** with the following classes of substances: alcohol; amphetamine and related substances; caffeine; cannabis; cocaine; hallucinogens; inhalants; phencyclidine and related substances; and other or unknown substances. Anxiety Disorders can occur in association with **withdrawal** from the following classes of substances: alcohol; cocaine; sedatives, hypnotics, and anxiolytics; and other or unknown substances.

Some of the medications reported to evoke anxiety symptoms include anesthetics and analgesics, sympathomimetics or other bronchodilators, anticholinergics, insulin, thyroid preparations, oral contraceptives, antihistamines, antiparkinsonian medications, corticosteroids, antihypertensive and cardiovascular medications, anticonvulsants, lithium carbonate, antipsychotic medications, and antidepressant medications. Heavy metals and toxins (e.g., volatile substances such as gasoline and paint, organophosphate insecticides, nerve gases, carbon monoxide, carbon dioxide) may also cause anxiety symptoms.

Differential Diagnosis

Anxiety symptoms commonly occur in **Substance Intoxication** and **Substance Withdrawal.** The diagnosis of the substance-specific intoxication or substance-specific withdrawal will usually suffice to categorize the symptom presentation. A diagnosis of Substance-Induced Anxiety Disorder should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the anxiety symptoms are judged to be in excess of those usually associated with the intoxication or withdrawal syndrome and when the anxiety symptoms are sufficiently severe to warrant independent clinical attention. For example, anxiety symptoms are a characteristic feature of Alcohol Withdrawal. Alcohol-Induced Anxiety Disorder should be diagnosed instead of Alcohol Withdrawal only if the anxiety symptoms are more severe than those usually encountered with Alcohol Withdrawal and are sufficiently severe to be a separate focus of attention and treatment. If substance-induced anxiety symptoms occur exclusively during the course of a **delirium,** the anxiety symptoms are considered to be an associated feature of the delirium and are not diagnosed separately. In **substance-induced presentations that contain a mix of different types of symptoms** (e.g., mood, psychotic, and anxiety), the specific type of Substance-Induced Disorder to be diagnosed depends on which type of symptoms predominates in the clinical presentation.

A Substance-Induced Anxiety Disorder is distinguished from a **primary Anxiety Disorder** by the fact that a substance is judged to be etiologically related to the symptoms (see p. 480).

A Substance-Induced Anxiety Disorder due to a prescribed treatment for a mental disorder or general medical condition must have its onset while the person is receiving the medication (or during withdrawal, if a withdrawal syndrome is associated with the medication). Once the treatment is discontinued, the anxiety symptoms will usually improve markedly or remit within days to several weeks to a month (depending on the half-life of the substance and the presence of a withdrawal syndrome). If symptoms persist beyond 4 weeks, other causes for the anxiety symptoms should be considered.

Because individuals with general medical conditions often take medications for those conditions, the clinician must consider the possibility that the anxiety symptoms are caused by the physiological consequences of the general medical condition rather than the medication, in which case **Anxiety Disorder Due to a General Medical Condition** is diagnosed. The history often provides the primary basis for such a judgment. At times, a change in the treatment for the general medical condition (e.g., medication substitution or discontinuation) may be needed to determine empirically for that person whether or not the medication is the causative agent. If the clinician has ascertained that the disturbance is due to both a general medical condition and substance use, both diagnoses (i.e., Anxiety Disorder Due to a General Medical Condition and Substance-Induced Anxiety Disorder) may be given. When there is insufficient evidence to determine whether the anxiety symptoms are due to a substance (including a medication) or to a general medical condition or are primary (i.e., not due to either a substance or a general medical condition), **Anxiety Disorder Not Otherwise Specified** would be indicated.

Diagnostic criteria for Substance-Induced Anxiety Disorder

A. Prominent anxiety, Panic Attacks, or obsessions or compulsions predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):

   (1) the symptoms in Criterion A developed during, or within 1 month of, Substance Intoxication or Withdrawal
   (2) medication use is etiologically related to the disturbance

C. The disturbance is not better accounted for by an Anxiety Disorder that is not substance induced. Evidence that the symptoms are better accounted for by an Anxiety Disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence suggesting the existence of an independent non-substance-induced Anxiety Disorder (e.g., a history of recurrent non-substance-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the anxiety symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the anxiety symptoms are sufficiently severe to warrant independent clinical attention.

Code [Specific Substance]–Induced Anxiety Disorder

(291.89 Alcohol; 292.89 Amphetamine (or Amphetamine-Like Substance); 292.89 Caffeine; 292.89 Cannabis; 292.89 Cocaine; 292.89 Hallucinogen; 292.89 Inhalant; 292.89 Phencyclidine (or Phencyclidine-Like Substance); 292.89 Sedative, Hypnotic, or Anxiolytic; 292.89 Other [or Unknown] Substance)

Specify if:

With Generalized Anxiety: if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation
With Panic Attacks: if Panic Attacks (see p. 432) predominate in the clinical presentation
With Obsessive-Compulsive Symptoms: if obsessions or compulsions predominate in the clinical presentation
With Phobic Symptoms: if phobic symptoms predominate in the clinical presentation

Specify if (see table on p. 193 for applicability by substance):

With Onset During Intoxication: if the criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome
With Onset During Withdrawal: if criteria are met for Withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome

300.00 Anxiety Disorder Not Otherwise Specified

This category includes disorders with prominent anxiety or phobic avoidance that do not meet criteria for any specific Anxiety Disorder, Adjustment Disorder With Anxiety, or Adjustment Disorder With Mixed Anxiety and Depressed Mood. Examples include

1. Mixed anxiety-depressive disorder: clinically significant symptoms of anxiety and depression, but the criteria are not met for either a specific Mood Disorder or a specific Anxiety Disorder (see p. 780 for suggested research criteria)
2. Clinically significant social phobic symptoms that are related to the social impact of having a general medical condition or mental disorder (e.g., Parkinson's disease, dermatological conditions, Stuttering, Anorexia Nervosa, Body Dysmorphic Disorder)
3. Situations in which the disturbance is severe enough to warrant a diagnosis of an Anxiety Disorder but the individual fails to report enough symptoms for the full criteria for any specific Anxiety Disorder to have been met; for example, an individual who reports all of the features of Panic Disorder Without Agoraphobia except that the Panic Attacks are all limited-symptom attacks
4. Situations in which the clinician has concluded that an Anxiety Disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced

Somatoform Disorders

The common feature of the Somatoform Disorders is the presence of physical symptoms that suggest a general medical condition (hence, the term *somatoform*) and are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder (e.g., Panic Disorder). The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning. In contrast to Factitious Disorders and Malingering, the physical symptoms are not intentional (i.e., under voluntary control). Somatoform Disorders differ from Psychological Factors Affecting Medical Condition in that there is no diagnosable general medical condition to fully account for the physical symptoms. The grouping of these disorders in a single section is based on clinical utility (i.e., the need to exclude occult general medical conditions or substance-induced etiologies for the bodily symptoms) rather than on assumptions regarding shared etiology or mechanism. These disorders are often encountered in general medical settings.

The following Somatoform Disorders are included in this section:

Somatization Disorder (historically referred to as hysteria or Briquet's syndrome) is a polysymptomatic disorder that begins before age 30 years, extends over a period of years, and is characterized by a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms.

Undifferentiated Somatoform Disorder is characterized by unexplained physical complaints, lasting at least 6 months, that are below the threshold for a diagnosis of Somatization Disorder.

Conversion Disorder involves unexplained symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptoms or deficits.

Pain Disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in its onset, severity, exacerbation, or maintenance.

Hypochondriasis is the preoccupation with the fear of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms or bodily functions.

Body Dysmorphic Disorder is the preoccupation with an imagined or exaggerated defect in physical appearance.

Somatoform Disorder Not Otherwise Specified is included for coding disorders with somatoform symptoms that do not meet the criteria for any of the specific Somatoform Disorders.

300.81 Somatization Disorder

Diagnostic Features

The essential feature of Somatization Disorder is a pattern of recurring, multiple, clinically significant somatic complaints. A somatic complaint is considered to be clinically significant if it results in medical treatment (e.g., the taking of medication) or causes significant impairment in social, occupational, or other important areas of functioning. The somatic complaints must begin before age 30 years and occur over a period of several years (Criterion A). The multiple somatic complaints cannot be fully explained by any known general medical condition or the direct effects of a substance. If they occur in the presence of a general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory tests (Criterion C). There must be a history of pain related to at least four different sites (e.g., head, abdomen, back, joints, extremities, chest, rectum) or functions (e.g., menstruation, sexual intercourse, urination) (Criterion B1). There also must be a history of at least two gastrointestinal symptoms other than pain (Criterion B2). Individuals with the disorder frequently describe the presence of nausea and abdominal bloating. Vomiting, diarrhea, and food intolerance are less common. Gastrointestinal complaints often lead to frequent X-ray examinations and can result in abdominal surgery that in retrospect was unnecessary. There must be a history of at least one sexual or reproductive symptom other than pain (Criterion B3). In women, this may consist of irregular menses, menorrhagia, or vomiting throughout pregnancy. In men, there may be symptoms such as erectile or ejaculatory dysfunction. Both women and men may be subject to sexual indifference. Finally, there must also be a history of at least one symptom, other than pain, that suggests a neurological condition (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, or seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting) (Criterion B4). The symptoms in each of the groups have been listed in the approximate order of their reported frequency. Finally, the unexplained symptoms in Somatization Disorder are not intentionally feigned or produced (as in Factitious Disorder or Malingering) (Criterion D).

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with Somatization Disorder usually describe their complaints in colorful, exaggerated terms, but specific factual information is often lacking. They are often inconsistent historians, so that a checklist approach to diagnostic interviewing may be less effective than a thorough review of medical treatments and hospitalizations to document a pattern of frequent somatic complaints. They often seek treatment from several physicians concurrently, which may lead to complicated and sometimes hazardous combinations of treatments. Prominent anxiety symptoms and depressed mood are very com-

mon and may be the reason for being seen in mental health settings. There may be impulsive and antisocial behavior, suicide threats and attempts, and marital discord. The lives of these individuals, particularly those with associated Personality Disorders, are often as chaotic and complicated as their medical histories. Frequent use of medications may lead to side effects and Substance-Related Disorders. These individuals commonly undergo numerous medical examinations, diagnostic procedures, surgeries, and hospitalizations, which expose the person to an increased risk of morbidity associated with these procedures. Major Depressive Disorder, Panic Disorder, and Substance-Related Disorders are frequently associated with Somatization Disorder. Histrionic, Borderline, and Antisocial Personality Disorders are the most frequently associated Personality Disorders.

Associated laboratory findings. Laboratory test results are remarkable for the absence of findings to support the subjective complaints.

Associated physical examination findings and general medical conditions. Physical examination is remarkable for the absence of objective findings to fully explain the many subjective complaints of individuals with Somatization Disorder. These individuals may be diagnosed with so-called functional disorders (e.g., irritable bowel syndrome). However, because these syndromes are as yet without established objective signs or specific laboratory findings, their symptoms may count toward a diagnosis of Somatization Disorder. Some individuals have objective findings and an associated general medical condition that does not fully explain the complaints. For example, individuals with hypothyroidism may present with multiple complaints and a significant number of objective findings, but the disease would not explain such a long history of numerous diverse complaints.

Specific Culture and Gender Features

The type and frequency of somatic symptoms may differ across cultures. For example, burning hands and feet or the nondelusional experience of worms in the head or ants crawling under the skin represent pseudoneurological symptoms that are more common in Africa and South Asia than in North America. Symptoms related to male reproductive function may be more prevalent in cultures in which there is widespread concern about semen loss (e.g., *dhat* syndrome in India). Accordingly, the symptom reviews should be adjusted to the culture. The symptoms listed in this manual are examples that have been found most diagnostic in the United States. It should be noted that the order of frequency was derived from studies carried out in the United States.

Somatization Disorder occurs only rarely in men in the United States, but the higher reported frequency in Greek and Puerto Rican men suggests that cultural factors may influence the sex ratio.

Prevalence

Studies have reported widely variable lifetime prevalence rates of Somatization Disorder, ranging from 0.2% to 2% among women and less than 0.2% in men. Differences

in rates may depend on whether the interviewer is a physician, on the method of assessment, and on the demographic variables in the samples studied. When nonphysician interviewers are used, Somatization Disorder is much less frequently diagnosed.

Course

Somatization Disorder is a chronic but fluctuating disorder that rarely remits completely. A year seldom passes without the individual's seeking some medical attention prompted by unexplained somatic complaints. Diagnostic criteria are typically met before age 25 years, but initial symptoms are often present by adolescence. Menstrual difficulties may be one of the earliest symptoms in women. Sexual symptoms are often associated with marital discord.

Familial Pattern

Somatization Disorder is observed in 10%–20% of female first-degree biological relatives of women with Somatization Disorder. The male relatives of women with this disorder show an increased risk of Antisocial Personality Disorder and Substance-Related Disorders. Adoption studies indicate that both genetic and environmental factors contribute to the risk for Antisocial Personality Disorder, Substance-Related Disorders, and Somatization Disorder. Having a biological or adoptive parent with any of these disorders increases the risk of developing either Antisocial Personality Disorder, a Substance-Related Disorder, or Somatization Disorder.

Differential Diagnosis

The symptom picture encountered in Somatization Disorder is frequently nonspecific and can overlap with a multitude of **general medical conditions.** Three features that suggest a diagnosis of Somatization Disorder rather than a general medical condition include 1) involvement of multiple organ systems, 2) early onset and chronic course without development of physical signs or structural abnormalities, and 3) absence of laboratory abnormalities that are characteristic of the suggested general medical condition. It is still necessary to rule out general medical conditions that are characterized by vague, multiple, and confusing somatic symptoms (e.g., systemic lupus erythematosus, hyperparathyroidism, multiple sclerosis, acute intermittent porphyria, hemochromatosis, Lyme disease, chronic parasitic disease). Moreover, Somatization Disorder does not protect individuals from having other independent general medical conditions. Objective findings should be evaluated without undue reliance on subjective complaints. The onset of multiple physical symptoms late in life is almost always due to a general medical condition.

Schizophrenia with multiple somatic delusions needs to be differentiated from the nondelusional somatic complaints of individuals with Somatization Disorder. In rare instances, individuals with Somatization Disorder also have Schizophrenia, in which case both diagnoses should be noted. Furthermore, hallucinations can occur as pseudoneurological symptoms and must be distinguished from the typical hallucinations seen in Schizophrenia (see p. 299).

It can be very difficult to distinguish between **Anxiety Disorders** and Somatization Disorder. In **Panic Disorder,** multiple somatic symptoms are also present, but these occur primarily during Panic Attacks. However, Panic Disorder may coexist with Somatization Disorder; when the somatic symptoms occur at times other than during Panic Attacks, both diagnoses may be made. Individuals with **Generalized Anxiety Disorder** may have a multitude of physical complaints associated with their generalized anxiety, but the focus of the anxiety and worry is not limited to the physical complaints. Individuals with **Mood Disorders,** particularly **Depressive Disorders,** may present with somatic complaints, most commonly headache, gastrointestinal disturbances, or unexplained pain. Individuals with Somatization Disorder have physical complaints recurrently throughout most of their lives, regardless of their current mood state, whereas physical complaints in Depressive Disorders are limited to episodes of depressed mood. Individuals with Somatization Disorder also often present with depressive complaints. If criteria are met for both Somatization Disorder and a Mood Disorder, both may be diagnosed.

By definition, all individuals with Somatization Disorder have a history of pain symptoms, sexual symptoms, and conversion or dissociative symptoms. Therefore, if these symptoms occur exclusively during the course of Somatization Disorder, there should not be an additional diagnosis of **Pain Disorder Associated With Psychological Factors,** a **Sexual Dysfunction, Conversion Disorder,** or a **Dissociative Disorder. Hypochondriasis** is not to be diagnosed if preoccupation with fears of having a serious illness occurs exclusively during the course of Somatization Disorder.

The criteria for Somatization Disorder in this manual are slightly more restrictive than the original criteria for **Briquet's syndrome.** Somatoform presentations that do not meet criteria for Somatization Disorder should be classified as **Undifferentiated Somatoform Disorder** if the duration of the syndrome is 6 months or longer, or **Somatoform Disorder Not Otherwise Specified** for presentations of shorter duration.

In **Factitious Disorder With Predominantly Physical Signs and Symptoms** and **Malingering,** somatic symptoms may be intentionally produced to assume the sick role or for gain, respectively. Symptoms that are intentionally produced should not count toward a diagnosis of Somatization Disorder. However, the presence of some factitious or malingered symptoms, mixed with other nonintentional symptoms, is not uncommon. In such mixed cases, both Somatization Disorder and a Factitious Disorder or Malingering should be diagnosed.

Diagnostic criteria for 300.81 Somatization Disorder

A. A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.

B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance:

(1) *four pain symptoms:* a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination)

(2) *two gastrointestinal symptoms:* a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance of several different foods)

(3) *one sexual symptom:* a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)

(4) *one pseudoneurological symptom:* a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting)

C. Either (1) or (2):

(1) after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)

(2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

D. The symptoms are not intentionally produced or feigned (as in Factitious Disorder or Malingering).

300.82 Undifferentiated Somatoform Disorder

Diagnostic Features

The essential feature of Undifferentiated Somatoform Disorder is one or more physical complaints (Criterion A) that persist for 6 months or longer (Criterion D). Frequent complaints include chronic fatigue, loss of appetite, or gastrointestinal or genitourinary symptoms. These symptoms cannot be fully explained by any known general medical condition or the direct effects of a substance (e.g., the effects of injury, substance use, or medication side effects), or the physical complaints or resultant impairment are grossly in excess of what would be expected from the history, physical

examination, or laboratory findings (Criterion B). The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The diagnosis is not made when the symptoms are better accounted for by another mental disorder (e.g., another Somatoform Disorder, Sexual Dysfunction, Mood Disorder, Anxiety Disorder, Sleep Disorder, or Psychotic Disorder) (Criterion E). The symptoms are not intentionally produced or feigned (as in Factitious Disorder or Malingering) (Criterion F).

This is a residual category for those persistent somatoform presentations that do not meet the full criteria for one of the specific Somatoform Disorders (e.g., Somatization Disorder). Particular care must be exercised to ensure the presentation does not meet the criteria for Somatization Disorder, because individuals with that disorder typically are inconsistent historians (i.e., reporting insufficient somatic symptomatology to meet the criteria at one assessment, but enough symptoms to meet the full criteria at another evaluation). Symptoms that may be seen include the examples listed for Somatization Disorder. There may be a single circumscribed symptom, such as nausea, or, more commonly, multiple physical symptoms. The chronic unexplained physical complaints often lead to medical consultation, typically with a primary care physician.

Specific Culture, Age, and Gender Features

Medically unexplained symptoms and worry about physical illness may constitute culturally shaped "idioms of distress" that are employed to express concerns about a broad range of personal and social problems, without necessarily indicating psychopathology. The highest frequency of unexplained physical complaints occurs in young women of low socioeconomic status, but such symptoms are not limited to any age, gender, or sociocultural group. "Neurasthenia," a syndrome described frequently in many parts of the world and characterized by fatigue and weakness, is classified in DSM-IV as Undifferentiated Somatoform Disorder if symptoms have persisted for longer than 6 months.

Course

The course of individual unexplained physical complaints is unpredictable. The eventual diagnosis of a general medical condition or another mental disorder is frequent.

Differential Diagnosis

Also refer to the Differential Diagnosis section for Somatization Disorder (see p. 488). Undifferentiated Somatoform Disorder is differentiated from **Somatization Disorder** by the requirement in Somatization Disorder of a multiplicity of symptoms of several years' duration and an onset before age 30 years. If the physical complaints have persisted for less than 6 months, a diagnosis of **Somatoform Disorder Not Otherwise Specified** should be made. Undifferentiated Somatoform Disorder is not diagnosed if the symptoms are better accounted for by another mental disorder. Other mental disorders that frequently include unexplained physical complaints are **Major De-**

pressive Disorder, Anxiety Disorders, and Adjustment Disorder. In contrast to Undifferentiated Somatoform Disorder, the physical symptoms of Factitious Disorders and Malingering are intentionally produced or feigned. In Factitious Disorder, the motivation is to assume the sick role and to obtain medical evaluation and treatment, whereas in Malingering, more external incentives are apparent, such as financial compensation, avoidance of duty, evasion of criminal prosecution, or obtaining drugs.

Diagnostic criteria for 300.82 Undifferentiated Somatoform Disorder

A. One or more physical complaints (e.g., fatigue, loss of appetite, gastrointestinal or urinary complaints).

B. Either (1) or (2):

(1) after appropriate investigation, the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)

(2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairment is in excess of what would be expected from the history, physical examination, or laboratory findings

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The duration of the disturbance is at least 6 months.

E. The disturbance is not better accounted for by another mental disorder (e.g., another Somatoform Disorder, Sexual Dysfunction, Mood Disorder, Anxiety Disorder, Sleep Disorder, or Psychotic Disorder).

F. The symptom is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

300.11 Conversion Disorder

Diagnostic Features

The essential feature of Conversion Disorder is the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition (Criterion A). Psychological factors are judged to be associated with the symptom or deficit, a judgment based on the observation that the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors (Criterion B). The symptoms are not intentionally produced or feigned, as in Factitious Disorder or Malingering (Criterion C). Conversion Disorder is not diagnosed if the symptoms or deficits are fully explained by a neurological or other general medical condition, by the direct effects of a substance, or as a culturally

sanctioned behavior or experience (Criterion D). The problem must be clinically significant as evidenced by marked distress; impairment in social, occupational, or other important areas of functioning; or the fact that it warrants medical evaluation (Criterion E). Conversion Disorder is not diagnosed if symptoms are limited to pain or sexual dysfunction, occur exclusively during the course of Somatization Disorder, or are better accounted for by another mental disorder (Criterion F).

Conversion symptoms are related to voluntary motor or sensory functioning and are thus referred to as "pseudoneurological." Motor symptoms or deficits include impaired coordination or balance, paralysis or localized weakness, aphonia, difficulty swallowing or a sensation of a lump in the throat, and urinary retention. Sensory symptoms or deficits include loss of touch or pain sensation, double vision, blindness, deafness, and hallucinations. Symptoms may also include seizures or convulsions. The more medically naive the person, the more implausible are the presenting symptoms. More sophisticated persons tend to have more subtle symptoms and deficits that may closely simulate neurological or other general medical conditions.

A diagnosis of Conversion Disorder should be made only after a thorough medical investigation has been performed to rule out an etiological neurological or general medical condition. Because a general medical etiology for many cases of apparent Conversion Disorder can take years to become evident, the diagnosis should be reevaluated periodically. In early studies, general medical etiologies were later found in from one-quarter to one-half of persons initially diagnosed with conversion symptoms. In more recent studies, misdiagnosis is less evident, perhaps reflecting increased awareness of the disorder, as well as improved knowledge and diagnostic techniques. A history of other unexplained somatic (especially conversion) or dissociative symptoms signifies a greater likelihood that an apparent conversion symptom is not due to a general medical condition, especially if criteria for Somatization Disorder have been met in the past.

Conversion symptoms typically do not conform to known anatomical pathways and physiological mechanisms, but instead follow the individual's conceptualization of a condition. A "paralysis" may involve inability to perform a particular movement or to move an entire body part, rather than a deficit corresponding to patterns of motor innervation. Conversion symptoms are often inconsistent. A "paralyzed" extremity will be moved inadvertently while dressing or when attention is directed elsewhere. If placed above the head and released, a "paralyzed" arm will briefly retain its position, then fall to the side, rather than striking the head. Unacknowledged strength in antagonistic muscles, normal muscle tone, and intact reflexes may be demonstrated. An electromyogram will be normal. Difficulty swallowing will be equal with liquids and solids. Conversion "anesthesia" of a foot or a hand may follow a so-called stocking-glove distribution with uniform (no proximal to distal gradient) loss of all sensory modalities (i.e., touch, temperature, and pain) sharply demarcated at an anatomical landmark rather than according to dermatomes. A conversion "seizure" will vary from convulsion to convulsion, and paroxysmal activity will not be evident on an EEG.

Even when following such guidelines carefully, caution must be exercised. Knowledge of anatomical and physiological mechanisms is incomplete, and available methods of objective assessment have limitations. A broad range of neurological conditions may be misdiagnosed as Conversion Disorder. Prominent among them

are multiple sclerosis, myasthenia gravis, and idiopathic or substance-induced dystonias. However, the presence of a neurological condition does not preclude a diagnosis of Conversion Disorder. As many as one-third of individuals with conversion symptoms have a current or prior neurological condition. Conversion Disorder may be diagnosed in the presence of a neurological or other general medical condition if the symptoms are not fully explained given the nature and severity of the neurological or other general medical condition.

Traditionally, the term *conversion* derived from the hypothesis that the individual's somatic symptom represents a symbolic resolution of an unconscious psychological conflict, reducing anxiety and serving to keep the conflict out of awareness ("primary gain"). The individual might also derive "secondary gain" from the conversion symptom—that is, external benefits are obtained or noxious duties or responsibilities are evaded. Although the DSM-IV criteria set for Conversion Disorder does not necessarily imply that the symptoms involve such constructs, it does require that psychological factors be associated with their onset or exacerbation. Because psychological factors are so ubiquitously present in relation to general medical conditions, it can be difficult to establish whether a specific psychological factor is etiologically related to the symptom or deficit. However, a close temporal relationship between a conflict or stressor and the initiation or exacerbation of a symptom may be helpful in this determination, especially if the person has developed conversion symptoms under similar circumstances in the past.

Although the individual may derive secondary gain from the conversion symptom, unlike in Malingering or Factitious Disorder the symptoms are not intentionally produced to obtain the benefits. The determination that a symptom is not intentionally produced or feigned can also be difficult. Generally, it must be inferred from a careful evaluation of the context in which the symptom develops, especially relative to potential external rewards or the assumption of the sick role. Supplementing the person's self-report with additional sources of information (e.g., from associates or records) may be helpful.

Conversion Disorder is not diagnosed if a symptom is fully explained as a culturally sanctioned behavior or experience. For example, "visions" or "spells" that occur as part of religious rituals in which such behaviors are encouraged and expected would not justify a diagnosis of Conversion Disorder unless the symptom exceeded what is contextually expected and caused undue distress or impairment. In "epidemic hysteria," shared symptoms develop in a circumscribed group of people following "exposure" to a common precipitant. A diagnosis of Conversion Disorder should be made only if the individual experiences clinically significant distress or impairment.

Subtypes

The following subtypes are noted based on the nature of the presenting symptom or deficit:

With Motor Symptom or Deficit. This subtype includes such symptoms as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or "lump in throat," aphonia, and urinary retention.

With Sensory Symptom or Deficit. This subtype includes such symptoms

as loss of touch or pain sensation, double vision, blindness, deafness, and hallucinations.

With Seizures or Convulsions. This subtype includes seizures or convulsions with voluntary motor or sensory components.

With Mixed Presentation. This subtype is used if symptoms of more than one category are evident.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with conversion symptoms may show *la belle indifference* (i.e., a relative lack of concern about the nature or implications of the symptom) or may also present in a dramatic or histrionic fashion. Because these individuals are often suggestible, their symptoms may be modified or resolved based on external cues; however, it must be cautioned that this is not specific to Conversion Disorder and may also occur with general medical conditions. Symptoms may be more common following extreme psychosocial stress (e.g., warfare or the recent death of a significant figure). Dependency and the adoption of a sick role may be fostered in the course of treatment. Other nonconversion somatic complaints are common. Associated mental disorders include Dissociative Disorders, Major Depressive Disorder, and Histrionic, Antisocial, Borderline, and Dependent Personality Disorders.

Associated laboratory findings. No specific laboratory abnormalities are associated with Conversion Disorder. In fact, it is the absence of expected findings that suggests and supports the diagnosis of Conversion Disorder. However, laboratory findings consistent with a general medical condition do not exclude the diagnosis of Conversion Disorder, because it only requires that a symptom not be fully explained by such a condition.

Associated physical examination findings and general medical conditions. Symptoms of Conversion Disorder typically do not conform to known anatomical pathways and physiological mechanisms. Thus, expected objective signs (e.g., reflex changes) are rarely present. However, a person may develop symptoms that resemble those observed in others or in themselves (e.g., individuals with epilepsy may simulate "seizures" that resemble those they have observed in others or how their own seizures were described to them). Generally, individual conversion symptoms are self-limited and do not lead to physical changes or disabilities. Rarely, physical changes such as atrophy and contractures may occur as a result of disuse or as sequelae to diagnostic or therapeutic procedures. It is important to note, however, that conversion symptoms can occur in individuals with neurological conditions.

Specific Culture, Age, and Gender Features

Conversion Disorder has been reported to be more common in rural populations, individuals of lower socioeconomic status, and individuals less knowledgeable about medical and psychological concepts. Higher rates of conversion symptoms are reported in developing regions, with the incidence generally declining with increasing

development. Falling down with loss or alteration of consciousness is a feature of a variety of culture-specific syndromes. The form of conversion symptoms reflects local cultural ideas about acceptable and credible ways to express distress. Changes resembling conversion symptoms (as well as dissociative symptoms) are common aspects of certain culturally sanctioned religious and healing rituals. The clinician must assess whether such symptoms are fully explained in the particular social context, and whether they result in clinically significant distress, disability, or role impairment.

Conversion symptoms in children under age 10 years are usually limited to gait problems or seizures. Conversion Disorder appears to be more frequent in women than in men, with reported ratios varying from 2:1 to 10:1. Especially in women, symptoms are much more common on the left than on the right side of the body. Women (rarely men) presenting with conversion symptoms may later manifest the full picture of Somatization Disorder. In men, there is an association between Conversion Disorder and Antisocial Personality Disorder. In addition, Conversion Disorder in men is often seen in the context of industrial accidents or the military.

Prevalence

Reported rates of Conversion Disorder have varied widely, ranging from 11/100,000 to 500/100,000 in general population samples. It has been reported in up to 3% of outpatient referrals to mental health clinics. Studies of general medical/surgical inpatients have identified conversion symptom rates ranging between 1% and 14%.

Course

The onset of Conversion Disorder is generally from late childhood to early adulthood, rarely before age 10 years or after age 35 years, but onset as late as the ninth decade of life has been reported. When an apparent Conversion Disorder first develops in middle or old age, the probability of an occult neurological or other general medical condition is high. The onset of Conversion Disorder is generally acute, but gradually increasing symptomatology may also occur. Typically, individual conversion symptoms are of short duration. In individuals hospitalized with conversion symptoms, symptoms will remit within 2 weeks in most cases. Recurrence is common, occurring in from one-fifth to one-quarter of individuals within 1 year, with a single recurrence predicting future episodes. Factors that are associated with good prognosis include acute onset, presence of clearly identifiable stress at the time of onset, a short interval between onset and the institution of treatment, and above-average intelligence. Symptoms of paralysis, aphonia, and blindness are associated with a good prognosis, whereas tremor and seizures are not.

Familial Pattern

Limited data suggest that conversion symptoms are more frequent in relatives of individuals with Conversion Disorder. Increased risk of Conversion Disorder in monozygotic twin pairs but not in dizygotic twin pairs has been reported.

Differential Diagnosis

The major diagnostic concern in evaluating potential conversion symptoms is the exclusion of **occult neurological** or **other general medical conditions** and **substance (including medication)–induced etiologies.** Appropriate evaluation of potential general medical conditions (e.g., multiple sclerosis, myasthenia gravis) should include careful review of the current presentation, the overall medical history, neurological and general physical examinations, and appropriate laboratory studies, including investigation for use of alcohol and other substances.

Pain Disorder or a **Sexual Dysfunction** is diagnosed instead of Conversion Disorder if the symptoms are limited to pain or to sexual dysfunction, respectively. An additional diagnosis of Conversion Disorder should not be made if conversion symptoms occur exclusively during the course of **Somatization Disorder.** Conversion Disorder is not diagnosed if symptoms are better accounted for by **another mental disorder** (e.g., catatonic symptoms or somatic delusions in **Schizophrenia** or **other Psychotic Disorders** or **Mood Disorder** or difficulty swallowing during a **Panic Attack**). In **Hypochondriasis,** the individual is preoccupied with the "serious disease" underlying the pseudoneurological symptoms, whereas in Conversion Disorder the focus is on the presenting symptom and there may be *la belle indifference.* In **Body Dysmorphic Disorder,** the emphasis is on a preoccupation with an imagined or slight defect in appearance, rather than a change in voluntary motor or sensory function. Conversion Disorder shares features with **Dissociative Disorders.** Both disorders involve symptoms that suggest neurological dysfunction and may also have shared antecedents. If both conversion and dissociative symptoms occur in the same individual (which is common), both diagnoses should be made.

It is controversial whether hallucinations ("pseudohallucinations") can be considered as the presenting symptom of Conversion Disorder. As distinguished from **hallucinations that occur in the context of a Psychotic Disorder** (e.g., Schizophrenia or another Psychotic Disorder, a Psychotic Disorder Due to a General Medical Condition, a Substance-Related Disorder, or a Mood Disorder With Psychotic Features), hallucinations in Conversion Disorder generally occur with intact insight in the absence of other psychotic symptoms, often involve more than one sensory modality (e.g., a hallucination involving visual, auditory, and tactile components), and often have a naive, fantastic, or childish content. They are often psychologically meaningful and tend to be described by the individual as an interesting story.

Symptoms of **Factitious Disorders** and **Malingering** are intentionally produced or feigned. In Factitious Disorder, the motivation is to assume the sick role and to obtain medical evaluation and treatment, whereas more obvious goals such as financial compensation, avoidance of duty, evasion of criminal prosecution, or obtaining drugs are apparent in Malingering. Such goals may resemble "secondary gain" in conversion symptoms, with the distinguishing feature of conversion symptoms being the lack of conscious intent in the production of the symptom.

Diagnostic criteria for 300.11 Conversion Disorder

A. One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.

B. Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.

C. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

D. The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, or by the direct effects of a substance, or as a culturally sanctioned behavior or experience.

E. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

F. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder.

Specify type of symptom or deficit:

With Motor Symptom or Deficit
With Sensory Symptom or Deficit
With Seizures or Convulsions
With Mixed Presentation

Pain Disorder

Diagnostic Features

The essential feature of Pain Disorder is pain that is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention (Criterion A). The pain causes significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). Psychological factors are judged to play a significant role in the onset, severity, exacerbation, or maintenance of the pain (Criterion C). The pain is not intentionally produced or feigned as in Factitious Disorder or Malingering (Criterion D). Pain Disorder is not diagnosed if the pain is better accounted for by a Mood, Anxiety, or Psychotic Disorder, or if the pain presentation meets criteria for Dyspareunia (Criterion E). Examples of impairment resulting from the pain include inability to work or attend school, frequent use of the health care system, the pain becoming a major focus of the individual's life, substantial use of medications, and relational problems such as marital discord and disruption of the family's normal lifestyle. The psychological factors involved may consist of another

Axis I or Axis II disorder (which would also be diagnosed) or may be of a nature that does not reach the threshold for such a disorder (e.g., reactions to psychosocial stressors).

Subtypes and Specifiers

Pain Disorder is coded according to the subtype that best characterizes the factors involved in the etiology and maintenance of the pain:

307.80 Pain Disorder Associated With Psychological Factors. This subtype is used when psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. In this subtype, general medical conditions play either no role or a minimal role in the onset or maintenance of the pain. This subtype is not diagnosed if criteria for Somatization Disorder are met.

307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition. This subtype is used when both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The anatomical site of the pain or associated general medical condition is coded on Axis III (see "Recording Procedures").

Pain Disorder Associated With a General Medical Condition. This subtype of Pain Disorder *is not considered a mental disorder and is coded on Axis III.* It is listed in this section to facilitate differential diagnosis. The pain results from a general medical condition, and psychological factors are judged to play either no role or a minimal role in the onset or maintenance of the pain. The ICD-9-CM code for this subtype is selected based on the location of the pain or the associated general medical condition if this has been established (see "Recording Procedures").

For Pain Disorder Associated With Psychological Factors and Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, the following specifiers may be noted to indicate the duration of the pain:

Acute. This specifier is used if the duration of the pain is less than 6 months.
Chronic. This specifier is used if the duration of the pain is 6 months or longer.

Recording Procedures

The diagnostic code for Pain Disorder is selected based on the subtype described above. The code is 307.80 for Pain Disorder Associated With Psychological Factors. For Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, 307.89 is coded on Axis I and the associated general medical condition or anatomical site of pain is coded on Axis III (e.g., 307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition on Axis I; 357.2 Diabetic Polyneuropathy on Axis III). For Pain Disorder Associated With a General Medical Condition, the diagnostic code for the pain is selected based on the associated general medical condition if one has been established (see Appendix G) or on the anatomical

location of the pain if the underlying general medical condition is not yet clearly established—for example, low back (724.2), sciatic (724.3), pelvic (625.9), headache (784.0), facial (784.0), chest (786.50), joint (719.40), bone (733.90), abdominal (789.0), breast (611.71), renal (788.0), ear (388.70), eye (379.91), throat (784.1), tooth (525.9), and urinary (788.0).

Associated Features and Disorders

Associated descriptive features and mental disorders. Pain may severely disrupt various aspects of daily life. Unemployment, disability, and family problems are frequently encountered among individuals with chronic forms of Pain Disorder. Iatrogenic Opioid Dependence or Abuse and Benzodiazepine Dependence or Abuse may develop. A history of Substance Dependence or Abuse, whether with an illicit drug or a prescribed medication, increases the risk for the development of Dependence or Abuse on a controlled substance prescribed for pain management. However, even individuals without any history of Substance Dependence or Abuse are at some risk for developing these problems. As many as a quarter of individuals prescribed opioids for treatment of chronic pain may develop Abuse or Dependence. The risk of iatrogenic Substance Dependence can be minimized by ensuring that the individual with pain has had an appropriate evaluation to rule out the possibility of a treatable underlying etiology for the pain; that if other mental disorders are present, they are appropriately treated; and that medications are prescribed by a single physician rather than having the individual obtaining them from multiple sources. Substance Dependence or Abuse (mostly with alcohol) may complicate the lifetime illness course of Pain Disorder in up to a quarter of individuals with chronic pain.

Individuals whose pain is associated with severe depression and those whose pain is related to a terminal illness, most notably cancer, appear to be at increased risk for suicide. Individuals with recurrent acute or chronic pain are sometimes convinced that there is a health professional somewhere who has the "cure" for the pain. They may spend a considerable amount of time and money seeking an unattainable goal. Health care professionals may unwittingly play a role in fostering this behavior.

Pain may lead to inactivity and social isolation, which in turn can lead to additional psychological problems (e.g., depression) and a reduction in physical endurance that results in fatigue and additional pain. Pain Disorder appears to be associated with other mental disorders, especially Mood and Anxiety Disorders. Chronic pain appears to be most frequently associated with Depressive and Anxiety Disorders, whereas acute pain appears to be more commonly associated with Anxiety Disorders. The associated mental disorders may precede the Pain Disorder (and possibly predispose the individual to it), co-occur with it, or result from it. Both the acute and chronic forms of Pain Disorder are frequently associated with various sleep problems. Common sleep symptoms in individuals with chronic pain include delayed sleep onset, frequent awakenings, nonrestorative sleep, and decreased sleep time. Sleep Disorders such as obstructive sleep apnea and nocturnal myoclonus occur at higher rates among individuals with chronic pain than in the general population.

Associated laboratory findings. In Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, appropriate laboratory testing may

reveal pathology that is associated with the pain (e.g., finding of a herniated lumbar disc on a magnetic resonance imaging (MRI) scan in an individual with radicular low-back pain). However, general medical conditions may also be present in the absence of objective findings. Conversely, the presence of such findings may be coincidental to the pain.

Associated physical examination findings and general medical conditions. In Pain Disorder Associated With Both Psychological Factors and a General Medical Condition, the physical examination may reveal pathology that is associated with the pain. Pain Disorder can be associated with many general medical conditions. Among the most common general medical conditions associated with pain are various musculoskeletal conditions (e.g., disc herniation, osteoporosis, osteoarthritis or rheumatoid arthritis, myofascial syndromes), neuropathies (e.g., diabetic neuropathies, postherpetic neuralgia), and malignancies (e.g., metastatic lesions in bone, tumor infiltration of nerves). Attempts to treat the pain may lead to additional problems, some of which can cause more pain (e.g., use of nonsteroidal anti-inflammatory drugs resulting in gastrointestinal distress, overuse of acetaminophen resulting in hepatic disease, surgery resulting in adhesions).

Specific Culture, Age, and Gender Features

There may be differences in how various ethnic and cultural groups respond to painful stimuli and how they express their reactions to pain. However, because there is so much individual variation, these factors are of limited usefulness in the evaluation and management of individuals with Pain Disorder.

Pain Disorder may occur at any age. Females appear to experience certain chronic pain conditions, most notably migraine and tension-type headaches and musculoskeletal pain, more often than do males.

Prevalence

Pain that causes significant distress or impairment in functioning is widespread. For example, it is estimated that, in any given year, 10%–15% of adults in the United States have some form of work disability due to back pain (only some of whom have Pain Disorder). However, the prevalence of Pain Disorder is unclear. Pain Disorder Associated With Both Psychological Factors and a General Medical Condition appears to be relatively common in certain clinical settings, particular those in which pain is a significant problem (e.g., pain clinics, psychiatric consultation services in a general medical hospital). Pain Disorder Associated With Psychological Factors appears to be much less common.

Course

Most acute pain resolves in relatively short periods of time. There is a wide range of variability in the onset of chronic pain, although it appears that the longer acute pain is present, the more likely it is to become chronic and persistent. In most cases, the pain has persisted for many years by the time the individual comes to the attention of

the mental health profession. Important factors that appear to influence recovery from Pain Disorder are the individual's acknowledgment of pain; giving up unproductive efforts to control pain; participation in regularly scheduled activities (e.g., work) despite the pain; degree of pain reduction; recognition and treatment of comorbid mental disorders; psychological adaptation to chronic illness; and not allowing the pain to become the determining factor in his or her lifestyle. Individuals with greater numbers of painful body areas and higher numbers of general medical symptoms other than pain have a poorer prognosis.

Familial Pattern

Depressive Disorders, Alcohol Dependence, and chronic pain may be more common in the first-degree biological relatives of individuals with chronic Pain Disorder.

Differential Diagnosis

Pain symptoms are included in the diagnostic criteria for **Somatization Disorder.** If the pain associated with psychological factors occurs exclusively during the course of Somatization Disorder, an additional diagnosis of Pain Disorder Associated With Psychological Factors is not made. Similarly, if the pain presentation meets criteria for **Dyspareunia** (i.e., pain associated with sexual intercourse), an additional diagnosis of Pain Disorder is not given. Pain complaints may be prominent in individuals with **Conversion Disorder,** but by definition, Conversion Disorder is not limited to pain symptoms. Pain symptoms are common associated features of **other mental disorders** (e.g., Depressive Disorders, Anxiety Disorders, Psychotic Disorders). An additional diagnosis of Pain Disorder should be considered only if the pain is an independent focus of clinical attention, leads to clinically significant distress or impairment, and is in excess of that usually associated with the other mental disorder.

Pain symptoms may be intentionally produced or feigned in **Factitious Disorder** or **Malingering.** In Factitious Disorder, the motivation is to assume the sick role and to obtain medical evaluation and treatment, whereas more obvious goals such as financial compensation, avoidance of duties related to military service or incarceration, evasion of criminal prosecution, or obtaining drugs are apparent in Malingering.

Relationship to the Taxonomy Proposed by The International Association for the Study of Pain

The Subcommittee on Taxonomy of The International Association for the Study of Pain proposed a five-axis system for categorizing chronic pain according to I) anatomical region, II) organ system, III) temporal characteristics of pain and pattern of occurrence, IV) patient's statement of intensity and time since onset of pain, and V) etiology. This five-axis system focuses primarily on the physical manifestations of pain. It provides for comments on psychological factors on both the second axis where the involvement of a mental disorder can be coded and the fifth axis where possible etiologies include "psychophysiological" and "psychological."

Diagnostic criteria for Pain Disorder

A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

Code as follows:

307.80 Pain Disorder Associated With Psychological Factors: psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. (If a general medical condition is present, it does not have a major role in the onset, severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder is not diagnosed if criteria are also met for Somatization Disorder.

Specify if:

Acute: duration of less than 6 months
Chronic: duration of 6 months or longer

307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition: both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The associated general medical condition or anatomical site of the pain (see below) is coded on Axis III.

Specify if:

Acute: duration of less than 6 months
Chronic: duration of 6 months or longer

Note: The following is not considered to be a mental disorder and is included here to facilitate differential diagnosis.

Pain Disorder Associated With a General Medical Condition: a general medical condition has a major role in the onset, severity, exacerbation, or maintenance of the pain. (If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain.) The diagnostic code for the pain is selected based on the associated general medical condition if one has been established (see Appendix G) or on the anatomical location of the pain if the underlying general medical condition is not yet clearly established—for example, low back (724.2), sciatic (724.3), pelvic (625.9), headache (784.0), facial (784.0), chest (786.50), joint (719.40), bone (733.90), abdominal (789.0), breast (611.71), renal (788.0), ear (388.70), eye (379.91), throat (784.1), tooth (525.9), and urinary (788.0).

300.7 Hypochondriasis

Diagnostic Features

The essential feature of Hypochondriasis is preoccupation with fears of having, or the idea that one has, a serious disease based on a misinterpretation of one or more bodily signs or symptoms (Criterion A). A thorough medical evaluation does not identify a general medical condition that fully accounts for the person's concerns about disease or for the physical signs or symptoms (although a coexisting general medical condition may be present). The unwarranted fear or idea of having a disease persists despite medical reassurance (Criterion B). However, the belief is not of delusional intensity (i.e., the person can acknowledge the possibility that he or she may be exaggerating the extent of the feared disease, or that there may be no disease at all). The belief is also not restricted to a circumscribed concern about appearance, as seen in Body Dysmorphic Disorder (Criterion C). The preoccupation with bodily symptoms causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D) and lasts for at least 6 months (Criterion E). The preoccupation is not better accounted for by Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, a Major Depressive Episode, Separation Anxiety, or another Somatoform Disorder (Criterion F).

The preoccupation in Hypochondriasis may be with bodily functions (e.g., heartbeat, sweating, or peristalsis); with minor physical abnormalities (e.g., a small sore or an occasional cough); or with vague and ambiguous physical sensations (e.g., "tired heart," "aching veins"). The person attributes these symptoms or signs to the suspected disease and is very concerned with their meaning, authenticity, and etiology. The concerns may involve several body systems, at different times or simultaneously. Alternatively, there may be preoccupation with a specific organ or a single disease (e.g., fear of having cardiac disease). Repeated physical examinations, diagnostic tests, and reassurance from the physician do little to allay the concern about bodily disease or affliction. For example, an individual preoccupied with having cardiac disease will not be reassured by the repeated lack of findings on physical examination, ECG, or even cardiac angiography. Individuals with Hypochondriasis may become alarmed by reading or hearing about disease, knowing someone who becomes sick, or from observations, sensations, or occurrences within their own bodies. Concern about the feared illness often becomes a central feature of the individual's self-image, a topic of social discourse, and a response to life stresses.

Specifier

With Poor Insight. This specifier is used if, for most of the time during the current episode, the individual does not recognize that the concern about having a serious illness is excessive or unreasonable.

Associated Features and Disorders

Associated descriptive features and mental disorders. Fears of aging and death are common. Although individuals with Hypochondriasis place greater importance

on physical health, they generally have no better health habits (e.g., healthy diet, regular exercise, avoidance of smoking) than individuals without the disorder. The medical history is often presented in great detail and at length in Hypochondriasis.

"Doctor-shopping" and deterioration in doctor-patient relationships, with frustration and anger on both sides, are common. Individuals with this disorder often believe that they are not getting proper care and may strenuously resist referral to mental health professionals. Complications may result from repeated diagnostic procedures that carry their own risks and are costly. However, because these individuals have a history of multiple complaints without a clear physical basis, they may receive cursory evaluations and the presence of a general medical condition may be missed. Social relationships become strained because the individual with Hypochondriasis is preoccupied with his or her condition and often expects special treatment and consideration. Family life may become disturbed as it becomes centered around the individual's physical well-being. Often, the preoccupation interferes with job performance and causes the person to miss time from work. In more severe cases, the individual with Hypochondriasis may become a complete invalid.

Serious illnesses, particularly in childhood, and past experience with disease in a family member are associated with the occurrence of Hypochondriasis. Psychosocial stressors, in particular the death of someone close to the individual, are thought to precipitate the disorder in some cases. Individuals with Hypochondriasis often have other mental disorders (particularly Anxiety, Depressive, and other Somatoform Disorders).

Associated laboratory findings. Laboratory findings do not confirm the individual's preoccupation.

Associated physical examination findings and general medical conditions. Physical examination findings do not confirm the individual's preoccupation.

Specific Culture and Gender Features

Whether it is unreasonable for the preoccupation with disease to persist despite appropriate medical evaluation and reassurance must be judged relative to the individual's cultural background and explanatory models. The diagnosis of Hypochondriasis should be made cautiously if the individual's ideas about disease have been reinforced by traditional healers who may disagree with the reassurances provided by medical evaluations. Findings with respect to age and gender differences in prevalence are inconsistent, but the disorder occurs across the lifespan in both men and women.

Prevalence

The prevalence of Hypochondriasis in the general population is 1%–5%. Among primary care outpatients, estimates of current prevalence range from 2% to 7%.

Course

Hypochondriasis can begin at any age, with the most common age at onset thought to be in early adulthood. The course is usually chronic, with waxing and waning symptoms, but complete recovery sometimes occurs. It appears that acute onset, brief duration, mild hypochondriacal symptoms, the presence of general medical comorbidity, the absence of a comorbid mental disorder, and the absence of secondary gain are favorable prognostic indicators. Because of its chronicity, some view this disorder as having prominent "traitlike" characteristics (i.e., a long-standing preoccupation with bodily complaints and focus on bodily symptoms).

Differential Diagnosis

The most important differential diagnostic consideration in Hypochondriasis is an underlying **general medical condition,** such as the early stages of neurological conditions (e.g., multiple sclerosis or myasthenia gravis), endocrine conditions (e.g., thyroid or parathyroid disease), diseases that affect multiple body systems (e.g., systemic lupus erythematosus), and occult malignancies. Although the presence of a general medical condition does not rule out the possibility of coexisting Hypochondriasis, transient preoccupations related to a current general medical condition do not constitute Hypochondriasis. **Somatic symptoms** (e.g., abdominal pain) are common **in children** and should not be diagnosed as Hypochondriasis unless the child has a prolonged preoccupation with having a serious illness. Bodily preoccupations and fears of debility may be frequent in elderly persons. However, the onset of **health concerns in old age** is more likely to be realistic or to reflect a Mood Disorder rather than Hypochondriasis.

A number of other disorders may be characterized by concerns about health or illness. Hypochondriasis is not diagnosed if the individual's health concerns are better accounted for by one of these disorders. For example, individuals with **Generalized Anxiety Disorder** worry about a number of events and activities that may include worries about having a disease. A separate diagnosis of Hypochondriasis should be considered only if the preoccupation with having an illness is the individual's predominant focus of concern. Some individuals in a **Major Depressive Episode** will be preoccupied with excessive worries over physical health. A separate diagnosis of Hypochondriasis is not made if these concerns occur only during Major Depressive Episodes. However, depression often occurs secondary to the Hypochondriasis, in which case Hypochondriasis should also be diagnosed.

Individuals with Hypochondriasis may have intrusive thoughts about having a disease and also may have associated compulsive behaviors (e.g., asking for reassurances). A separate diagnosis of **Obsessive-Compulsive Disorder** is given only when the obsessions or compulsions are not restricted to concerns about illness (e.g., checking locks). Occasionally, individuals with Hypochondriasis experience Panic Attacks that are triggered by hypochondriacal concerns. However, a separate diagnosis of **Panic Disorder** is made only when recurrent unexpected Panic Attacks are also present. In **Body Dysmorphic Disorder,** the concern is limited to the person's physical appearance. In contrast to a **Specific** ("disease") **Phobia** in which the individual is fearful of developing or being exposed to a disease, Hypochondriasis is characterized by a preoccupation that one has the disease.

In Hypochondriasis, the disease conviction does not reach delusional proportions (i.e., the individual can entertain the possibility that the feared disease is not present), as opposed to somatic delusions that can occur in **Psychotic Disorders** (e.g., Schizophrenia, Delusional Disorder, Somatic Type, and Major Depressive Disorder, With Psychotic Features).

Diagnostic criteria for 300.7 Hypochondriasis

A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.

B. The preoccupation persists despite appropriate medical evaluation and reassurance.

C. The belief in Criterion A is not of delusional intensity (as in Delusional Disorder, Somatic Type) and is not restricted to a circumscribed concern about appearance (as in Body Dysmorphic Disorder).

D. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The duration of the disturbance is at least 6 months.

F. The preoccupation is not better accounted for by Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, a Major Depressive Episode, Separation Anxiety, or another Somatoform Disorder.

Specify if:

With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the concern about having a serious illness is excessive or unreasonable

300.7 Body Dysmorphic Disorder

Diagnostic Features

The essential feature of Body Dysmorphic Disorder (historically known as dysmorphophobia) is a preoccupation with a defect in appearance (Criterion A). The defect is either imagined, or, if a slight physical anomaly is present, the individual's concern is markedly excessive (Criterion A). The preoccupation must cause significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa) (Criterion C).

Complaints commonly involve imagined or slight flaws of the face or head such as hair thinning, acne, wrinkles, scars, vascular markings, paleness or redness of the complexion, swelling, facial asymmetry or disproportion, or excessive facial hair. Other common preoccupations include the shape, size, or some other aspect of the nose, eyes, eyelids, eyebrows, ears, mouth, lips, teeth, jaw, chin, cheeks, or head. However, any other body part may be the focus of concern (e.g., the genitals, breasts,

buttocks, abdomen, arms, hands, feet, legs, hips, shoulders, spine, larger body regions, overall body size, or body build and muscularity). The preoccupation may simultaneously focus on several body parts. Although the complaint is often specific (e.g., a "crooked" lip or a "bumpy" nose), it is sometimes vague (e.g., a "falling" face or "inadequately firm" eyes). Because of embarrassment over their concerns or for other reasons, some individuals with Body Dysmorphic Disorder avoid describing their "defects" in detail and may instead refer only to their general ugliness.

Most individuals with this disorder experience marked distress over their supposed deformity, often describing their preoccupations as "intensely painful," "tormenting," or "devastating." Most find their preoccupations difficult to control, and they may make little or no attempt to resist them. As a result, they often spend hours a day thinking about their "defect," to the point where these thoughts may dominate their lives. Significant impairment in many areas of functioning generally occurs. Feelings of self-consciousness about their "defect" may lead to avoidance of work, school, or public situations.

Associated Features and Disorders

Frequent checking of the defect, either directly or in a reflecting surface (e.g., mirrors, store windows, car bumpers, watch faces) can consume many hours a day. Some individuals use special lighting or magnifying glasses to scrutinize their "defect." There may be excessive grooming behavior (e.g., excessive hair combing, hair removal, ritualized makeup application, or skin picking). Although the usual intent of checking and grooming is to diminish anxiety, be reassured about one's appearance, or temporarily improve one's appearance, these behaviors often intensify the preoccupation and associated anxiety. Consequently, some individuals avoid mirrors, sometimes covering them or removing them from their environment. Others alternate between periods of excessive mirror checking and avoidance. Other behaviors aimed at improving the "defect" include excessive exercise (e.g., weight lifting), dieting, and frequent changing of clothes. There may be frequent requests for reassurance about the "defect," but such reassurance leads to only temporary, if any, relief. Individuals with the disorder may also frequently compare their "ugly" body part with that of others. They may try to camouflage the "defect" (e.g., growing a beard to cover imagined facial scars, wearing a hat to hide imagined hair loss, stuffing their shorts to enhance a "small" penis). Some individuals may be excessively preoccupied with fears that the "ugly" body part will malfunction or is extremely fragile and in constant danger of being damaged. Insight about the perceived defect is often poor, and some individuals are delusional; that is, they are completely convinced that their view of the defect is accurate and undistorted, and they cannot be convinced otherwise. Ideas and delusions of reference related to the imagined defect are also common; that is, individuals with this disorder often think that others may be (or are) taking special notice of their supposed flaw, perhaps talking about it or mocking it.

Avoidance of usual activities may lead to extreme social isolation. In some cases, individuals may leave their homes only at night, when they cannot be seen, or become housebound, sometimes for years. Individuals with this disorder may drop out of school, avoid job interviews, work at jobs below their capacity, or not work at all. They may have few friends, avoid dating and other social interactions, have marital

difficulties, or get divorced because of their symptoms. The distress and dysfunction associated with this disorder, although variable, can lead to repeated hospitalization and to suicidal ideation, suicide attempts, and completed suicide. Individuals with Body Dysmorphic Disorder often pursue and receive general medical (often dermatological), dental, or surgical treatments to rectify their imagined or slight defects. Occasionally, individuals may resort to extreme measures (e.g., self-surgery) to correct their perceived flaws.

Such treatment may cause the disorder to worsen, leading to intensified or new preoccupations, which may in turn lead to further unsuccessful procedures, so that individuals may eventually possess "synthetic" noses, ears, breasts, hips, or other body parts, which they are still dissatisfied with. Body Dysmorphic Disorder may be associated with Major Depressive Disorder, Delusional Disorder, Social Phobia, and Obsessive-Compulsive Disorder.

Specific Culture and Gender Features

Cultural concerns about physical appearance and the importance of proper physical self-presentation may influence or amplify preoccupations about an imagined physical deformity. Body Dysmorphic Disorder may be equally common in women and in men in outpatient mental health settings.

Prevalence

The prevalence of Body Dysmorphic Disorder in the community is unknown. In clinical mental health settings, reported rates of Body Dysmorphic Disorder in individuals with Anxiety or Depressive Disorders range from under 5% to approximately 40%. In cosmetic surgery and dermatology settings, reported rates of Body Dysmorphic Disorder range from 6% to 15%.

Course

Body Dysmorphic Disorder usually begins during adolescence but can begin during childhood. However, the disorder may not be diagnosed for many years, often because individuals with the disorder are reluctant to reveal their symptoms. The onset may be either gradual or abrupt. The disorder often has a fairly continuous course, with few symptom-free intervals, although the intensity of symptoms may wax and wane over time. The part of the body on which concern is focused may remain the same or may change.

Differential Diagnosis

Unlike **normal concerns about appearance,** the preoccupation with appearance in Body Dysmorphic Disorder is excessively time consuming and associated with significant distress or impairment in social, occupational, or other areas of functioning. However, Body Dysmorphic Disorder may be underrecognized in settings in which cosmetic procedures are performed. The excessive exercising (e.g., weight lifting) that can occur in Body Dysmorphic Disorder to correct a perceived appearance flaw

should be differentiated from **healthy exercising** and from excessive exercising that may occur as part of an **Eating Disorder.**

The diagnosis of Body Dysmorphic Disorder should not be made if the preoccupation is better accounted for by **another mental disorder.** Body Dysmorphic Disorder should not be diagnosed if the excessive preoccupation is restricted to concerns about "fatness" in **Anorexia Nervosa,** if the individual's preoccupation is limited to discomfort with or a sense of inappropriateness about his or her primary and secondary sex characteristics occurring in **Gender Identity Disorder,** or if the preoccupation is limited to mood-congruent ruminations involving appearance that occur exclusively during a **Major Depressive Episode.** However, depression often occurs secondary to Body Dysmorphic Disorder, in which case Body Dysmorphic Disorder should be diagnosed.

Individuals with **Avoidant Personality Disorder** or **Social Phobia** may worry about being embarrassed by real defects in appearance, but this concern is usually not prominent, persistent, distressing, time consuming, and impairing. Although individuals with Body Dysmorphic Disorder have obsessional preoccupations about their appearance and may have associated compulsive behaviors (e.g., mirror checking), a separate diagnosis of **Obsessive-Compulsive Disorder** is given only when the obsessions or compulsions are not restricted to concerns about appearance. Some individuals with Body Dysmorphic Disorder remove body hair or pick their skin in an attempt to improve their appearance; these behaviors should be distinguished from hair pulling in **Trichotillomania,** which does not occur in response to appearance concerns, and from skin picking that may be associated with other mental disorders.

Individuals with Body Dysmorphic Disorder can receive an additional diagnosis of **Delusional Disorder, Somatic Type,** if their preoccupation with an imagined defect in appearance is held with a delusional intensity.

Koro is a culture-related syndrome that occurs primarily in Southeast Asia that may be related to Body Dysmorphic Disorder. It is characterized by the preoccupation that the penis (or labia, nipples, or breast in women) is shrinking or retracting and will disappear into the abdomen. This preoccupation is often accompanied by a belief that death will result. Koro differs from Body Dysmorphic Disorder by its usually brief duration, different associated features (primarily acute anxiety and fear of death), positive response to reassurance, and occasional occurrence as an epidemic.

Diagnostic criteria for 300.7 Body Dysmorphic Disorder

A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.

B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa).

300.82 Somatoform Disorder Not Otherwise Specified

This category includes disorders with somatoform symptoms that do not meet the criteria for any specific Somatoform Disorder. Examples include

1. Pseudocyesis: a false belief of being pregnant that is associated with objective signs of pregnancy, which may include abdominal enlargement (although the umbilicus does not become everted), reduced menstrual flow, amenorrhea, subjective sensation of fetal movement, nausea, breast engorgement and secretions, and labor pains at the expected date of delivery. Endocrine changes may be present, but the syndrome cannot be explained by a general medical condition that causes endocrine changes (e.g., a hormone-secreting tumor).
2. A disorder involving nonpsychotic hypochondriacal symptoms of less than 6 months' duration.
3. A disorder involving unexplained physical complaints (e.g., fatigue or body weakness) of less than 6 months' duration that are not due to another mental disorder.

Factitious Disorders

Factitious Disorders are characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role. The judgment that a particular symptom is intentionally produced is made both by direct evidence and by excluding other causes of the symptom. For example, an individual presenting with hematuria is found to have anticoagulants in his possession. The person denies having taken them, but blood studies are consistent with the ingestion of anticoagulants. A reasonable inference, in the absence of evidence that accidental ingestion occurred, is that the individual may have taken the medication intentionally. It should be noted that the presence of factitious symptoms does not preclude the coexistence of true physical or psychological symptoms.

Factitious Disorders are distinguished from acts of Malingering. In Malingering, the individual also produces the symptoms intentionally, but has a goal that is obviously recognizable when the environmental circumstances are known. For example, the intentional production of symptoms to avoid jury duty, standing trial, or conscription into the military would be classified as Malingering. Similarly, if an individual who is hospitalized for treatment of a mental disorder simulates an exacerbation of illness to avoid transfer to another, less desirable facility, this would be an act of Malingering. In contrast, in Factitious Disorder, the motivation is a psychological need to assume the sick role, as evidenced by an absence of external incentives for the behavior. Malingering may be considered to be adaptive under certain circumstances (e.g., in hostage situations), but by definition a diagnosis of a Factitious Disorder always implies psychopathology.

Factitious Disorder

The essential feature of Factitious Disorder is the intentional production of physical or psychological signs or symptoms (Criterion A). The presentation may include fabrication of subjective complaints (e.g., complaints of acute abdominal pain in the absence of any such pain), falsification of objective signs (e.g., manipulating a thermometer to create the illusion of fever), self-inflicted conditions (e.g., the production of abscesses by injection of saliva into the skin), exaggeration or exacerbation of preexisting general medical conditions (e.g., feigning of a grand mal seizure by an individual with a previous history of seizure disorder), or any combination or variation of these. The motivation for the behavior is to assume the sick role (Criterion B). External incentives for the behavior (e.g., economic gain, avoiding legal responsibility, or improving physical well-being, as in Malingering) are absent (Criterion C).

Individuals with Factitious Disorder usually present their history with dramatic flair, but are extremely vague and inconsistent when questioned in greater detail.

They may engage in pathological lying, in a manner that is intriguing to the listener, about any aspect of their history or symptoms (i.e., pseudologia fantastica). They often have extensive knowledge of medical terminology and hospital routines. Complaints of pain and requests for analgesics are very common. After an extensive workup of their initial chief complaints has proved negative, they often complain of other physical or psychological problems and produce more factitious symptoms. Individuals with this disorder may eagerly undergo multiple invasive procedures and operations. While in the hospital, they usually have few visitors. Eventually, a point may be reached at which the factitious nature of the individual's symptoms is revealed (e.g., the person is recognized by someone who encountered the patient during a previous admission; other hospitals confirm multiple prior hospitalizations for factitious symptomatology). When confronted with evidence that their symptoms are factitious, individuals with this disorder usually deny the allegations or rapidly discharge themselves against medical advice. Sometimes, they will be admitted to another hospital soon after. Their repeated hospitalizations may take them to numerous cities, states, and countries.

Subtypes

Factitious Disorder is coded according to the subtype that best characterizes the predominant symptoms.

300.16 With Predominantly Psychological Signs and Symptoms. This subtype describes a clinical presentation in which psychological signs and symptoms predominate. It is characterized by the intentional production or feigning of psychological symptoms that are suggestive of a mental disorder. The individual's goal is apparently to assume the "patient" role and is not otherwise understandable in light of environmental circumstances (in contrast to the case in Malingering). This subtype may be suggested by a wide-ranging symptomatology that often does not correspond to a typical syndromal pattern, an unusual course and response to treatment, and the worsening of symptoms when the individual is aware of being observed. Individuals with this subtype of Factitious Disorder may claim problems such as depression and suicidal ideation following the death of a spouse (the death not being confirmed by other informants), memory loss (recent and remote), hallucinations or delusions, symptoms of Posttraumatic Stress Disorder, and dissociative symptoms. Some individuals may discern from the examiner's questions the symptoms to endorse during a review of systems. Conversely, they may be extremely negativistic and uncooperative when questioned. The presentation usually represents the individual's concept of mental disorder and may not conform to any recognized diagnostic category.

300.19 With Predominantly Physical Signs and Symptoms. This subtype describes a clinical presentation in which signs and symptoms of an apparent general medical condition predominate. Common clinical problems that may be feigned or produced include infection (e.g., abscesses), impaired wound healing, pain, hypoglycemia, anemia, bleeding, rashes, neurological symptoms (e.g., seizures, dizziness, or blacking out), vomiting, diarrhea, fevers of

undetermined origin, and symptoms of autoimmune or connective tissue disease. The most severe and chronic form of this disorder has been referred to as "Münchausen's syndrome," consisting of the core elements of recurrent hospitalization, peregrination (traveling), and pseudologia fantastica. All organ systems are potential targets, and the symptoms presented are limited only by the individual's medical knowledge, sophistication, and imagination.

300.19 With Combined Psychological and Physical Signs and Symptoms. This subtype describes a clinical presentation in which both psychological and physical signs and symptoms are present, but neither predominates.

Associated Features and Disorders

In Factitious Disorder With Predominantly Psychological Signs and Symptoms, the intentional giving of approximate answers may occur (e.g., "8 times 8 equals 65"). The individual may surreptitiously use psychoactive substances for the purpose of producing symptoms that suggest a mental disorder (e.g., stimulants to produce restlessness or insomnia, hallucinogens to induce altered perceptual states, analgesics to induce euphoria, and hypnotics to induce lethargy). Combinations of psychoactive substances can produce very unusual presentations.

Individuals with Factitious Disorder With Predominantly Physical Signs and Symptoms may also present with Substance Abuse, particularly of prescribed analgesics and sedatives. Multiple hospitalizations frequently lead to iatrogenically induced general medical conditions (e.g., the formation of scar tissue from unnecessary surgery, or adverse drug reactions). Individuals with the chronic form of this disorder may acquire a "gridiron abdomen" from multiple surgical procedures. Chronic Factitious Disorder is usually incompatible with the individual's maintaining steady employment, family ties, and interpersonal relationships. Possible predisposing factors to Factitious Disorder may include the presence of other mental disorders or general medical conditions during childhood or adolescence that led to extensive medical treatment and hospitalization; family disruption or emotional or physical abuse in childhood; a grudge against the medical profession; employment in a medically related position; and the presence of a severe Personality Disorder, most often Borderline Personality Disorder.

Specific Gender Features

Factitious Disorder is more common in females than in males. However, the most chronic and severe (Munchausen) variant appears to be more frequent in males than in females.

Prevalence

There is limited information on the prevalence of Factitious Disorder. Standard epidemiological techniques are constrained by the fact that Factitious Disorder always involves deception and sometimes peregrination as well, and so it often may not be recognized. On the other hand, the chronic form of the disorder may be overreported because affected individuals appear to different physicians at different hospitals, of-

ten under different names. The best data indicate that, within large general hospitals, Factitious Disorder is diagnosed in around 1% of patients on whom mental health professionals consult. The prevalence appears to be greater in highly specialized treatment settings. Presentations with Predominantly Psychological Signs and Symptoms are reported much less commonly than those with Predominantly Physical Signs and Symptoms.

Course

The course of Factitious Disorder usually consists of intermittent episodes. Less common is a single episode or chronic, unremitting illness. The onset is usually in early adulthood, often after a hospitalization for a general medical condition or other mental disorder. In the chronic form of this disorder, a pattern of successive hospitalizations may become a lifelong pattern.

Differential Diagnosis

A Factitious Disorder must be distinguished from a **true general medical condition** and from a **true mental disorder.** Suspicion that an apparent mental disorder or general medical condition in fact represents Factitious Disorder should be aroused if any combination of the following is noted in a hospitalized individual: an atypical or dramatic presentation that does not conform to an identifiable general medical condition or mental disorder; symptoms or behaviors that are present only when the individual is being observed; pseudologia fantastica; disruptive behavior on the ward (e.g., noncompliance with hospital regulations, arguing excessively with nurses and physicians); extensive knowledge of medical terminology and hospital routines; covert use of substances; evidence of multiple treatment interventions (e.g., repeated surgery, repeated courses of electroconvulsive therapy); extensive history of traveling; few, if any, visitors while hospitalized; and a fluctuating clinical course, with rapid development of "complications" or new "pathology" once the initial workup proves to be negative. However, it should be noted that the absence of objective signs (e.g., a demonstrable lesion) is not necessarily an indication that the symptoms (e.g., pain) are intentionally produced.

In **Somatoform Disorders,** physical complaints that are not fully attributable to a true general medical condition are also present, but the symptoms are not intentionally produced. **Malingering** differs from Factitious Disorder in that in Malingering, the individual is consciously motivated by an external incentive. Individuals with Malingering may seek hospitalization by producing symptoms in attempts to obtain compensation, avoid prosecution, or simply "get a bed for the night." However, the goal is usually apparent, and they can "stop" the symptoms when the symptoms are no longer useful to them. In Factitious Disorder, the individual is usually not aware of the motivation behind the factitious behavior and external incentives are absent.

Diagnostic criteria for Factitious Disorder

A. Intentional production or feigning of physical or psychological signs or symptoms.

B. The motivation for the behavior is to assume the sick role.

C. External incentives for the behavior (such as economic gain, avoiding legal responsibility, or improving physical well-being, as in Malingering) are absent.

Code based on type:

300.16 With Predominantly Psychological Signs and Symptoms: if psychological signs and symptoms predominate in the clinical presentation

300.19 With Predominantly Physical Signs and Symptoms: if physical signs and symptoms predominate in the clinical presentation

300.19 With Combined Psychological and Physical Signs and Symptoms: if both psychological and physical signs and symptoms are present but neither predominates in the clinical presentation

300.19 Factitious Disorder Not Otherwise Specified

This category includes disorders with factitious symptoms that do not meet the criteria for Factitious Disorder. An example is factitious disorder by proxy: the intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role (see p. 781 for suggested research criteria).

Dissociative Disorders

The essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception. The disturbance may be sudden or gradual, transient or chronic. The following disorders are included in this section:

Dissociative Amnesia is characterized by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.

Dissociative Fugue is characterized by sudden, unexpected travel away from home or one's customary place of work, accompanied by an inability to recall one's past and confusion about personal identity or the assumption of a new identity.

Dissociative Identity Disorder (formerly Multiple Personality Disorder) is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. It is a disorder characterized by identity fragmentation rather than a proliferation of separate personalities.

Depersonalization Disorder is characterized by a persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing.

Dissociative Disorder Not Otherwise Specified is included for coding disorders in which the predominant feature is a dissociative symptom, but that do not meet the criteria for any specific Dissociative Disorder.

Dissociative symptoms are also included in the criteria sets for Acute Stress Disorder, Posttraumatic Stress Disorder, and Somatization Disorder. An additional Dissociative Disorder diagnosis is not given if the dissociative symptoms occur exclusively during the course of one of these disorders. In some classifications, conversion reaction is considered to be a dissociative phenomenon; however, in DSM-IV, Conversion Disorder is placed in the "Somatoform Disorders" section to emphasize the importance of considering neurological or other general medical conditions in the differential diagnosis.

A cross-cultural perspective is particularly important in the evaluation of Dissociative Disorders because dissociative states are a common and accepted expression of cultural activities or religious experience in many societies. In most such instances, the dissociative states are not pathological and do not lead to significant distress, impairment, or help-seeking behavior. However, a number of culturally defined syndromes characterized by dissociation do cause distress and impairment and are recognized indigenously as manifestations of pathology (see p. 783 and p. 897), although the symptomatology may take different forms in different cultures, such as recurrent brief episodes of dissociative stupor or spirit possession in India.

300.12 Dissociative Amnesia (*formerly* Psychogenic Amnesia)

Diagnostic Features

The essential feature of Dissociative Amnesia is an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by normal forgetfulness (Criterion A). This disorder involves a reversible memory impairment in which memories of personal experience cannot be retrieved in a verbal form (or, if temporarily retrieved, cannot be wholly retained in consciousness). The disturbance does not occur exclusively during the course of Dissociative Identity Disorder, Dissociative Fugue, Posttraumatic Stress Disorder, Acute Stress Disorder, or Somatization Disorder and is not due to the direct physiological effects of a substance or a neurological or other general medical condition (Criterion B). The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C).

Dissociative Amnesia most commonly presents as a retrospectively reported gap or series of gaps in recall for aspects of the individual's life history. These gaps are usually related to traumatic or extremely stressful events. Some individuals may have amnesia for episodes of self-mutilation, violent outbursts, or suicide attempts. Less commonly, Dissociative Amnesia presents as a florid episode with sudden onset. This acute form is more likely to occur during wartime or in response to a natural disaster or other forms of severe trauma.

Several types of memory disturbances have been described in Dissociative Amnesia. In *localized amnesia,* the individual fails to recall events that occurred during a circumscribed period of time, usually the first few hours following a profoundly disturbing event (e.g., the uninjured survivor of a car accident in which a family member has been killed may not be able to recall anything that happened from the time of the accident until 2 days later). In *selective amnesia,* the person can recall some, but not all, of the events during a circumscribed period of time (e.g., a combat veteran can recall only some parts of a series of violent combat experiences). Three other types of amnesia—generalized, continuous, and systematized—are less common. In *generalized amnesia,* failure of recall encompasses the person's entire life. Individuals with this rare disorder usually present to the police, to emergency rooms, or to general hospital consultation-liaison services. *Continuous amnesia* is defined as the inability to recall events subsequent to a specific time up to and including the present. *Systematized amnesia* is loss of memory for certain categories of information, such as all memories relating to one's family or to a particular person. Individuals who exhibit these latter three types of Dissociative Amnesia may ultimately be diagnosed as having a more complex form of Dissociative Disorder (e.g., Dissociative Identity Disorder).

Associated Features and Disorders

Associated descriptive features and mental disorders. Some individuals with Dissociative Amnesia report depressive symptoms, anxiety, depersonalization, trance states, analgesia, and spontaneous age regression. They may provide approximate in-

accurate answers to questions (e.g., "2 plus 2 equals 5") as in Ganser syndrome. Other problems that sometimes accompany this disorder include sexual dysfunction, impairment in work and interpersonal relationships, self-mutilation, aggressive impulses, and suicidal impulses and acts. Individuals with Dissociative Amnesia may also have symptoms that meet criteria for Conversion Disorder, a Mood Disorder, a Substance-Related Disorder, or a Personality Disorder.

Associated laboratory findings. Individuals with Dissociative Amnesia often display high hypnotizability as measured by standardized testing.

Specific Age Features

Dissociative Amnesia is especially difficult to assess in preadolescent children, because it may be confused with inattention, anxiety, oppositional behavior, Learning Disorders, psychotic disturbances, and developmentally appropriate childhood amnesia (i.e., the decreased recall of autobiographical events that occurred before age 5). Serial observation or evaluations by several different examiners (e.g., teacher, therapist, case worker) may be needed to make an accurate diagnosis of Dissociative Amnesia in children.

Prevalence

In recent years, there has been an increase in reported cases of Dissociative Amnesia that involves previously forgotten early childhood traumas. This increase has been subject to very different interpretations. Some believe that the greater awareness of the diagnosis among mental health professionals has resulted in the identification of cases that were previously undiagnosed. In contrast, others believe that the syndrome has been overdiagnosed in individuals who are highly suggestible.

Course

Dissociative Amnesia can present in any age group, from young children to adults. The main manifestation in most individuals is a retrospective gap in memory. The reported duration of the events for which there is amnesia may be minutes to years. Only a single episode of amnesia may be reported, although two or more episodes are also commonly described. Individuals who have had one episode of Dissociative Amnesia may be predisposed to develop amnesia for subsequent traumatic circumstances. Acute amnesia may resolve spontaneously after the individual is removed from the traumatic circumstances with which the amnesia was associated (e.g., a soldier with localized amnesia after several days of intense combat may spontaneously regain memory of these experiences after being removed from the battlefield). Some individuals with chronic amnesia may gradually begin to recall dissociated memories. Other individuals may develop a chronic form of amnesia.

Differential Diagnosis

Dissociative Amnesia must be distinguished from **Amnestic Disorder Due to a General Medical Condition,** in which the amnesia is judged to be the direct physiological

consequence of a specific neurological or other general medical condition (e.g., head trauma, epilepsy) (see p. 175). This determination is based on history, laboratory findings, or physical examination. In **Amnestic Disorder Due to a Brain Injury,** the disturbance of recall, though circumscribed, is often both retrograde (i.e., encompassing a period of time before the head trauma) and anterograde (i.e., for events after the trauma), and there is usually a history of a clear-cut physical trauma, a period of unconsciousness, or clinical evidence of brain injury. In contrast, in Dissociative Amnesia, the disturbance of recall is almost always anterograde (i.e., memory loss is restricted to the period after the trauma), and there are typically no problems with learning new information. The rare case of Dissociative Amnesia with retrograde amnesia can be distinguished by the diagnostic use of hypnosis; the prompt recovery of the lost memories suggests a dissociative basis for the disturbance. In **seizure disorders,** the memory impairment is sudden in onset, motor abnormalities may be present, and repeated EEGs reveal typical abnormalities. In **delirium** and **dementia,** the memory loss for personal information is embedded in a far more extensive set of cognitive, linguistic, affective, attentional, perceptual, and behavioral disturbances. In contrast, in Dissociative Amnesia, the memory loss is primarily for autobiographical information and cognitive abilities generally are preserved. The amnesia associated with a general medical condition usually cannot be reversed.

Memory loss associated with the use of substances or medications must be distinguished from Dissociative Amnesia. **Substance-Induced Persisting Amnestic Disorder** should be diagnosed if it is judged that there is a persistent loss of memory that is related to the direct physiological effects of a substance (e.g., a drug of abuse or a medication) (see p. 177). Whereas the ability to lay down new memories is preserved in Dissociative Amnesia, in Substance-Induced Persisting Amnestic Disorder, short-term memory is impaired (i.e., events may be recalled immediately after they occur, but not after a few minutes have passed). Memory loss associated with **Substance Intoxication** (e.g., "blackouts") can be distinguished from Dissociative Amnesia by the association of the memory loss with heavy substance use and the fact that the amnesia usually cannot be reversed.

The dissociative symptom of amnesia is a characteristic feature of both Dissociative Fugue and Dissociative Identity Disorder. Therefore, if the dissociative amnesia occurs exclusively during the course of **Dissociative Fugue** or **Dissociative Identity Disorder,** a separate diagnosis of Dissociative Amnesia is not made. Because depersonalization is an associated feature of Dissociative Amnesia, depersonalization that occurs only during Dissociative Amnesia should not be diagnosed separately as **Depersonalization Disorder.**

In **Posttraumatic Stress Disorder** and **Acute Stress Disorder,** there can be amnesia for the traumatic event. Similarly, dissociative symptoms such as amnesia are included in the criteria set for **Somatization Disorder.** Dissociative Amnesia is not diagnosed if it occurs exclusively during the course of these disorders.

Malingered amnesia is most common in individuals presenting with acute, florid symptoms in a context in which potential secondary gain is evident—for example, financial or legal problems or the desire to avoid combat, although true amnesia may also be associated with such stressors. Furthermore, individuals with true Dissociative Amnesia usually score high on standard measures of hypnotizability and dissociative capacity.

Care must be exercised in evaluating the accuracy of retrieved memories. There has been considerable controversy concerning amnesia related to reported physical or sexual abuse, particularly when abuse is alleged to have occurred during early childhood. Some clinicians believe that there has been an underreporting of such events, especially because the victims are often children and perpetrators are inclined to deny or distort their actions. However, other clinicians are concerned that there may be overreporting, particularly given the unreliability of childhood memories. There is currently no method for establishing with certainty the accuracy of such retrieved memories in the absence of corroborative evidence.

Dissociative Amnesia must also be differentiated from memory loss related to **Age-Related Cognitive Decline** and **nonpathological forms of amnesia** including everyday memory loss, posthypnotic amnesia, infantile and childhood amnesia, and amnesia for sleep and dreaming. Dissociative Amnesia can be distinguished from normal gaps in memory by the extensive and involuntary nature of the inability to recall the content of the lost memory (i.e., memories of a traumatic nature) and by the presence of significant distress or impairment.

Diagnostic criteria for 300.12 Dissociative Amnesia

A. The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.

B. The disturbance does not occur exclusively during the course of Dissociative Identity Disorder, Dissociative Fugue, Posttraumatic Stress Disorder, Acute Stress Disorder, or Somatization Disorder and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a neurological or other general medical condition (e.g., Amnestic Disorder Due to Head Trauma).

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

300.13 Dissociative Fugue (*formerly* Psychogenic Fugue)

Diagnostic Features

The essential feature of Dissociative Fugue is sudden, unexpected travel away from home or one's customary place of daily activities, with inability to recall some or all of one's past (Criterion A). This is accompanied by confusion about personal identity or even the assumption of a new identity (Criterion B). The disturbance does not occur exclusively during the course of Dissociative Identity Disorder and is not due to the direct physiological effects of a substance or a general medical condition (Criterion C). The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D).

Travel may range from brief trips over relatively short periods of time (i.e., hours or days) to complex, usually unobtrusive wandering over long time periods (e.g., weeks or months), with some individuals reportedly crossing numerous national borders and traveling thousands of miles. During a fugue, individuals may appear to be without psychopathology and generally do not attract attention. At some point, the individual is brought to clinical attention, usually because of amnesia for recent events or a lack of awareness of personal identity. Once the individual returns to the prefugue state, there may be no memory for the events that occurred during the fugue.

Most fugues do not involve the formation of a new identity. If a new identity is assumed during a fugue, it is usually characterized by more gregarious and uninhibited traits than characterized the former identity. The person may assume a new name, take up a new residence, and engage in complex social activities that are well integrated and that do not suggest the presence of a mental disorder.

Associated Features and Disorders

Associated descriptive features and mental disorders. After return to the prefugue state, amnesia for traumatic events in the person's past may be noted (e.g., after termination of a long fugue, a soldier remains amnestic for wartime events that occurred several years previously in which the soldier's closest friend was killed). Depression, dysphoria, anxiety, grief, shame, guilt, psychological stress, conflict, and suicidal and aggressive impulses may be present. The person may provide approximate inaccurate answers to questions (e.g., "2 plus 2 equals 5") as in Ganser syndrome. The extent and duration of the fugue may determine the degree of other problems, such as loss of employment or severe disruption of personal or family relationships. Individuals with Dissociative Fugue may have a Mood Disorder, Posttraumatic Stress Disorder, or a Substance-Related Disorder.

Specific Culture Features

Individuals with various culturally defined "running" syndromes (e.g., *pibloktoq* among native peoples of the Arctic, *grisi siknis* among the Miskito of Honduras and Nicaragua, Navajo "frenzy" witchcraft, and some forms of *amok* in Western Pacific cultures) may have symptoms that meet diagnostic criteria for Dissociative Fugue. These are conditions characterized by a sudden onset of a high level of activity, a trancelike state, potentially dangerous behavior in the form of running or fleeing, and ensuing exhaustion, sleep, and amnesia for the episode. (See also Dissociative Trance Disorder in Appendix B, p. 783.)

Prevalence

A prevalence rate of 0.2% for Dissociative Fugue has been reported in the general population. The prevalence may increase during times of extremely stressful events such as wartime or natural disaster.

Course

The onset of Dissociative Fugue is usually related to traumatic, stressful, or overwhelming life events. Most cases are described in adults. Single episodes are most commonly reported and may last from hours to months. Recovery is usually rapid, but refractory Dissociative Amnesia may persist in some cases.

Differential Diagnosis

Dissociative Fugue must be distinguished from symptoms that are judged to be the **direct physiological consequence of a specific general medical condition** (e.g., head injury) (see p. 181). This determination is based on history, laboratory findings, or physical examination. Individuals with **complex partial seizures** have been noted to exhibit wandering or semipurposeful behavior during seizures or during postictal states for which there is subsequent amnesia. However, an epileptic fugue can usually be recognized because the individual may have an aura, motor abnormalities, stereotyped behavior, perceptual alterations, a postictal state, and abnormal findings on serial EEGs. Dissociative symptoms that are judged to be the direct physiological consequence of a general medical condition should be diagnosed as **Mental Disorder Not Otherwise Specified Due to a General Medical Condition.** Dissociative Fugue must also be distinguished from symptoms caused by the **direct physiological effects of a substance** (see p. 209).

If the fugue symptoms only occur during the course of **Dissociative Identity Disorder,** Dissociative Fugue should not be diagnosed separately. **Dissociative Amnesia** and **Depersonalization Disorder** should not be diagnosed separately if the amnesia or depersonalization symptoms occur only during the course of a Dissociative Fugue. Wandering and purposeful travel that occur during a **Manic Episode** must be distinguished from Dissociative Fugue. As in Dissociative Fugue, individuals in a Manic Episode may report amnesia for some period of their life, particularly for behavior that occurs during euthymic or depressed states. However, in a Manic Episode, the travel is associated with grandiose ideas and other manic symptoms and such individuals often call attention to themselves by inappropriate behavior. Assumption of an alternate identity does not occur.

Peripatetic behavior may also occur in **Schizophrenia.** Memory for events during wandering episodes in individuals with Schizophrenia may be difficult to ascertain due to the individual's disorganized speech. However, individuals with Dissociative Fugue generally do not demonstrate any of the psychopathology associated with Schizophrenia (e.g., delusions, negative symptoms).

Malingered fugue states may occur in individuals who are attempting to flee a situation involving legal, financial, or personal difficulties, as well as in soldiers who are attempting to avoid combat or unpleasant military duties (although true Dissociative Fugue may also be associated with such stressors). Malingering of dissociative symptoms can be maintained even during hypnotic or barbiturate-facilitated interviews. In the forensic context, the examiner should always give careful consideration to the diagnosis of malingering when fugue is claimed. Criminal conduct that is bizarre or with little actual gain may be more consistent with a true dissociative disturbance.

Diagnostic criteria for 300.13 Dissociative Fugue

A. The predominant disturbance is sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past.

B. Confusion about personal identity or assumption of a new identity (partial or complete).

C. The disturbance does not occur exclusively during the course of Dissociative Identity Disorder and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

300.14 Dissociative Identity Disorder (*formerly* Multiple Personality Disorder)

Diagnostic Features

The essential feature of Dissociative Identity Disorder is the presence of two or more distinct identities or personality states (Criterion A) that recurrently take control of behavior (Criterion B). There is an inability to recall important personal information, the extent of which is too great to be explained by ordinary forgetfulness (Criterion C). The disturbance is not due to the direct physiological effects of a substance or a general medical condition (Criterion D). In children, the symptoms cannot be attributed to imaginary playmates or other fantasy play.

Dissociative Identity Disorder reflects a failure to integrate various aspects of identity, memory, and consciousness. Each personality state may be experienced as if it has a distinct personal history, self-image, and identity, including a separate name. Usually there is a primary identity that carries the individual's given name and is passive, dependent, guilty, and depressed. The alternate identities frequently have different names and characteristics that contrast with the primary identity (e.g., are hostile, controlling, and self-destructive). Particular identities may emerge in specific circumstances and may differ in reported age and gender, vocabulary, general knowledge, or predominant affect. Alternate identities are experienced as taking control in sequence, one at the expense of the other, and may deny knowledge of one another, be critical of one another, or appear to be in open conflict. Occasionally, one or more powerful identities allocate time to the others. Aggressive or hostile identities may at times interrupt activities or place the others in uncomfortable situations.

Individuals with this disorder experience frequent gaps in memory for personal history, both remote and recent. The amnesia is frequently asymmetrical. The more passive identities tend to have more constricted memories, whereas the more hostile, controlling, or "protector" identities have more complete memories. An identity that is not in control may nonetheless gain access to consciousness by producing auditory

or visual hallucinations (e.g., a voice giving instructions). Evidence of amnesia may be uncovered by reports from others who have witnessed behavior that is disavowed by the individual or by the individual's own discoveries (e.g., finding items of clothing at home that the individual cannot remember having bought). There may be loss of memory not only for recurrent periods of time, but also an overall loss of biographical memory for some extended period of childhood, adolescence, or even adulthood. Transitions among identities are often triggered by psychosocial stress. The time required to switch from one identity to another is usually a matter of seconds, but, less frequently, may be gradual. Behavior that may be frequently associated with identity switches include rapid blinking, facial changes, changes in voice or demeanor, or disruption in the individual's train of thoughts. The number of identities reported ranges from 2 to more than 100. Half of reported cases include individuals with 10 or fewer identities.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with Dissociative Identity Disorder frequently report having experienced severe physical and sexual abuse, especially during childhood. Controversy surrounds the accuracy of such reports, because childhood memories may be subject to distortion and some individuals with this disorder are highly hypnotizable and especially vulnerable to suggestive influences. However, reports by individuals with Dissociative Identity Disorder of a past history of sexual or physical abuse are often confirmed by objective evidence. Furthermore, persons responsible for acts of physical and sexual abuse may be prone to deny or distort their behavior. Individuals with Dissociative Identity Disorder may manifest posttraumatic symptoms (e.g., nightmares, flashbacks, and startle responses) or Posttraumatic Stress Disorder. Self-mutilation and suicidal and aggressive behavior may occur. Some individuals may have a repetitive pattern of relationships involving physical and sexual abuse. Certain identities may experience conversion symptoms (e.g., pseudoseizures) or have unusual abilities to control pain or other physical symptoms. Individuals with this disorder may also have symptoms that meet criteria for Mood, Substance-Related, Sexual, Eating, or Sleep Disorders. Self-mutilative behavior, impulsivity, and sudden and intense changes in relationships may warrant a concurrent diagnosis of Borderline Personality Disorder.

Associated laboratory findings. Individuals with Dissociative Identity Disorder score toward the upper end of the distribution on measures of hypnotizability and dissociative capacity. There are reports of variation in physiological function across identity states (e.g., differences in visual acuity, pain tolerance, symptoms of asthma, sensitivity to allergens, and response of blood glucose to insulin).

Associated physical examination findings and general medical conditions. There may be scars from self-inflicted injuries or physical abuse. Individuals with this disorder may have migraine and other types of headaches, irritable bowel syndrome, and asthma.

Specific Culture, Age, and Gender Features

Dissociative Identity Disorder has been found in individuals from a variety of cultures around the world. In preadolescent children, particular care is needed in making the diagnosis because the manifestations may be less distinctive than in adolescents and adults. Dissociative Identity Disorder is diagnosed three to nine times more frequently in adult females than in adult males; in childhood, the female-to-male ratio may be more even, but data are limited. Females tend to have more identities than do males, averaging 15 or more, whereas males average approximately 8 identities.

Prevalence

The sharp rise in reported cases of Dissociative Identity Disorder in the United States in recent years has been subject to very different interpretations. Some believe that the greater awareness of the diagnosis among mental health professionals has resulted in the identification of cases that were previously undiagnosed. In contrast, others believe that the syndrome has been overdiagnosed in individuals who are highly suggestible.

Course

Dissociative Identity Disorder appears to have a fluctuating clinical course that tends to be chronic and recurrent. The average time period from first symptom presentation to diagnosis is 6–7 years. Episodic and continuous courses have both been described. The disorder may become less manifest as individuals age beyond their late 40s, but may reemerge during episodes of stress or trauma or with Substance Abuse.

Familial Pattern

Several studies suggest that Dissociative Identity Disorder is more common among the first-degree biological relatives of persons with the disorder than in the general population.

Differential Diagnosis

Dissociative Identity Disorder must be distinguished from **symptoms that are caused by the direct physiological effects of a general medical condition** (e.g., seizure disorder) (see p. 181). This determination is based on history, laboratory findings, or physical examination. Dissociative Identity Disorder should be distinguished from **dissociative symptoms due to complex partial seizures,** although the two disorders may co-occur. Seizure episodes are generally brief (30 seconds to 5 minutes) and do not involve the complex and enduring structures of identity and behavior typically found in Dissociative Identity Disorder. Also, a history of physical and sexual abuse is less common in individuals with complex partial seizures. EEG studies, especially sleep deprived and with nasopharyngeal leads, may help clarify the differential diagnosis.

Symptoms caused by the **direct physiological effects of a substance** can be distinguished from Dissociative Identity Disorder by the fact that a substance (e.g., a drug of abuse or a medication) is judged to be etiologically related to the disturbance (see p. 209).

The diagnosis of Dissociative Identity Disorder takes precedence over **Dissociative Amnesia, Dissociative Fugue,** and **Depersonalization Disorder.** Individuals with Dissociative Identity Disorder can be distinguished from those with trance and possession trance symptoms that would be diagnosed as **Dissociative Disorder Not Otherwise Specified** by the fact that those with pathological trance and possession trance symptoms typically describe external spirits or entities that have entered their bodies and taken control.

The differential diagnosis between Dissociative Identity Disorder and a variety of **other mental disorders** (including **Schizophrenia** and **other Psychotic Disorders, Bipolar Disorder, With Rapid Cycling, Anxiety Disorders, Somatization Disorders,** and **Personality Disorders**) is complicated by the apparently overlapping symptom presentations. For example, the presence of more than one dissociated personality state may be mistaken for a delusion or the communication from one identity to another may be mistaken for an auditory hallucination, leading to confusion with the Psychotic Disorders, and shifts between identity states may be confused with cyclical mood fluctuations leading to confusion with Bipolar Disorder). Factors that may support a diagnosis of Dissociative Identity Disorder are the presence of clear-cut dissociative symptomatology with sudden shifts in identity states, the persistence and consistency of identity-specific demeanors and behaviors over time, reversible amnesia, evidence of dissociative behavior that predates the clinical or forensic presentation (e.g., reports by family or co-workers), and high scores on measures of dissociation and hypnotizability in individuals who do not have the characteristic presentations of another mental disorder.

Dissociative Identity Disorder must be distinguished from **Malingering** in situations in which there may be financial or forensic gain and from **Factitious Disorder** in which there may be a pattern of help-seeking behavior.

Diagnostic criteria for 300.14 Dissociative Identity Disorder

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behavior.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). **Note:** In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

300.6 Depersonalization Disorder

Diagnostic Features

The essential features of Depersonalization Disorder are persistent or recurrent episodes of depersonalization characterized by a feeling of detachment or estrangement from one's self (Criterion A). The individual may feel like an automaton or as if he or she is living in a dream or a movie. There may be a sensation of being an outside observer of one's mental processes, one's body, or parts of one's body. Various types of sensory anesthesia, lack of affective response, and a sensation of lacking control of one's actions, including speech, are often present. The individual with Depersonalization Disorder maintains intact reality testing (e.g., awareness that it is only a feeling and that he or she is not really an automaton) (Criterion B). Depersonalization is a common experience, and this diagnosis should be made only if the symptoms are sufficiently severe to cause marked distress or impairment in functioning (Criterion C). Because depersonalization is a common associated feature of many other mental disorders, a separate diagnosis of Depersonalization Disorder is not made if the experience occurs exclusively during the course of another mental disorder (e.g., Schizophrenia, Panic Disorder, Acute Stress Disorder, or another Dissociative Disorder). In addition, the disturbance is not due to the direct physiological effects of a substance or a general medical condition (Criterion D).

Associated Features and Disorders

Associated descriptive features and mental disorders. Often individuals with Depersonalization Disorder may have difficulty describing their symptoms and may fear that these experiences signify that they are "crazy." Derealization may also be present and is experienced as the sense that the external world is strange or unreal. The individual may perceive an uncanny alteration in the size or shape of objects (macropsia or micropsia), and people may seem unfamiliar or mechanical. Other common associated features include anxiety symptoms, depressive symptoms, obsessive rumination, somatic concerns, and a disturbance in one's sense of time. Hypochondriasis, Major Depressive or Dysthymic Disorder, Anxiety Disorders, Personality Disorders (most commonly Avoidant, Borderline, and Obsessive-Compulsive), and Substance-Related Disorders may also coexist with Depersonalization Disorder. Depersonalization and derealization are very frequent symptoms of Panic Attacks and are more common when anxiety symptoms follow a traumatic stressor, as in Posttraumatic Stress Disorder. A separate diagnosis of Depersonalization Disorder should not be made when the depersonalization and derealization occur exclusively during such attacks.

Associated laboratory findings. Individuals with Depersonalization Disorder may display high hypnotizability and high dissociative capacity as measured by standardized testing.

Specific Culture and Gender Features

Voluntarily induced experiences of depersonalization or derealization form part of meditative and trance practices that are prevalent in many religions and cultures and should not be confused with Depersonalization Disorder. In clinical samples, this disorder is diagnosed at least twice as often in women than in men.

Prevalence

The lifetime prevalence of Depersonalization Disorder in community and clinical settings is unknown. At some time in their lives, approximately half of all adults may have experienced a single brief episode of depersonalization, usually precipitated by severe stress. A transient experience of depersonalization develops in nearly one-third of individuals exposed to life-threatening danger and in close to 40% of patients hospitalized for mental disorders.

Course

Individuals with Depersonalization Disorder usually present for treatment in adolescence or adulthood, although the disorder may have an undetected onset in childhood. The mean age at onset has been reported to be around age 16. Because depersonalization is rarely the presenting complaint, individuals with recurrent depersonalization often present with another symptom such as anxiety, panic, or depression. Duration of episodes of depersonalization can vary from very brief (seconds) to persistent (years). Depersonalization subsequent to life-threatening situations (e.g., military combat, traumatic accidents, being a victim of violent crime) usually develops suddenly on exposure to the trauma, and trauma histories are often associated with this disorder. The course is usually chronic and may wax and wane in intensity but is also sometimes episodic. Most often the exacerbations occur in association with actual or perceived stressful events.

Differential Diagnosis

Depersonalization Disorder must be distinguished from **symptoms that are due to the physiological consequences of a specific general medical condition** (e.g., epilepsy) (see p. 181). This determination is based on history, laboratory findings, or physical examination. **Depersonalization that is caused by the direct physiological effects of a substance** is distinguished from Depersonalization Disorder by the fact that a substance (e.g., a drug of abuse or a medication) is judged to be etiologically related to the depersonalization (see p. 209). **Acute Intoxication** or **Withdrawal** from alcohol and a variety of other substances can result in depersonalization. On the other hand, substance use may intensify the symptoms of a preexisting Depersonalization Disorder. Thus, accurate diagnosis of Depersonalization Disorder in individuals with a history of alcohol- or substance-induced depersonalization should include a longitudinal history of Substance Abuse and depersonalization symptoms.

Depersonalization Disorder should not be diagnosed separately when the symptoms occur only during a Panic Attack that is part of **Panic Disorder, Social** or

Specific Phobia, or **Posttraumatic** or **Acute Stress Disorders.** In contrast to **Schizophrenia,** intact reality testing is maintained in Depersonalization Disorder. The feeling of numbness associated with depersonalization may mimic a **depression.** However, feelings of numbness in individuals with Depersonalization Disorder are associated with other manifestations of depersonalization (e.g., a sense of detachment from one's self) and occur even when the individual is not depressed.

Diagnostic criteria for 300.6 Depersonalization Disorder

A. Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream).

B. During the depersonalization experience, reality testing remains intact.

C. The depersonalization causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The depersonalization experience does not occur exclusively during the course of another mental disorder, such as Schizophrenia, Panic Disorder, Acute Stress Disorder, or another Dissociative Disorder, and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

300.15 Dissociative Disorder Not Otherwise Specified

This category is included for disorders in which the predominant feature is a dissociative symptom (i.e., a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment) that does not meet the criteria for any specific Dissociative Disorder. Examples include

1. Clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder. Examples include presentations in which a) there are not two or more distinct personality states, or b) amnesia for important personal information does not occur.
2. Derealization unaccompanied by depersonalization in adults.
3. States of dissociation that occur in individuals who have been subjected to periods of prolonged and intense coercive persuasion (e.g., brainwashing, thought reform, or indoctrination while captive).
4. Dissociative trance disorder: single or episodic disturbances in the state of consciousness, identity, or memory that are indigenous to particular locations and cultures. Dissociative trance involves narrowing of awareness of immediate surroundings or stereotyped behaviors or movements that are experienced as being beyond one's control. Possession trance involves replacement of the customary sense of personal identity by a new identity, attributed to the influence of a spirit, power, deity, or other person, and associated with stereotyped "involuntary"

movements or amnesia and is perhaps the most common Dissociative Disorder in Asia. Examples include *amok* (Indonesia), *bebainan* (Indonesia), *latah* (Malaysia), *pibloktoq* (Arctic), *ataque de nervios* (Latin America), and possession (India). The dissociative or trance disorder is not a normal part of a broadly accepted collective cultural or religious practice. (See p. 785 for suggested research criteria.)

5. Loss of consciousness, stupor, or coma not attributable to a general medical condition.
6. Ganser syndrome: the giving of approximate answers to questions (e.g., "2 plus 2 equals 5") when not associated with Dissociative Amnesia or Dissociative Fugue.

Sexual and Gender Identity Disorders

This section contains the Sexual Dysfunctions, the Paraphilias, and the Gender Identity Disorders. The **Sexual Dysfunctions** are characterized by disturbance in sexual desire and in the psychophysiological changes that characterize the sexual response cycle and cause marked distress and interpersonal difficulty. The Sexual Dysfunctions include Sexual Desire Disorders (i.e., Hypoactive Sexual Desire Disorder, Sexual Aversion Disorder), Sexual Arousal Disorders (i.e., Female Sexual Arousal Disorder, Male Erectile Disorder), Orgasmic Disorders (i.e., Female Orgasmic Disorder, Male Orgasmic Disorder, Premature Ejaculation), Sexual Pain Disorders (i.e., Dyspareunia, Vaginismus), Sexual Dysfunction Due to a General Medical Condition, Substance-Induced Sexual Dysfunction, and Sexual Dysfunction Not Otherwise Specified.

The **Paraphilias** are characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The Paraphilias include Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Masochism, Sexual Sadism, Transvestic Fetishism, Voyeurism, and Paraphilia Not Otherwise Specified.

Gender Identity Disorders are characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one's assigned sex. *Gender identity* refers to an individual's self-perception as male or female. The term *gender dysphoria* denotes strong and persistent feelings of discomfort with one's assigned sex, the desire to possess the body of the other sex, and the desire to be regarded by others as a member of the other sex. The terms gender identity and gender dysphoria should be distinguished from the term *sexual orientation*, which refers to erotic attraction to males, females, or both.

Sexual Disorder Not Otherwise Specified is included for coding disorders of sexual functioning that are not classifiable in any of the specific categories. It is important to note that notions of deviance, standards of sexual performance, and concepts of appropriate gender role can vary from culture to culture.

Sexual Dysfunctions

A Sexual Dysfunction is characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse. The sexual response cycle can be divided into the following phases:

1. *Desire:* This phase consists of fantasies about sexual activity and the desire to have sexual activity.
2. *Excitement:* This phase consists of a subjective sense of sexual pleasure and accompanying physiological changes. The major changes in the male consist of penile tumescence and erection. The major changes in the female consist of vasocongestion in the pelvis, vaginal lubrication and expansion, and swelling of the external genitalia.
3. *Orgasm:* This phase consists of a peaking of sexual pleasure, with release of sexual tension and rhythmic contraction of the perineal muscles and reproductive organs. In the male, there is the sensation of ejaculatory inevitability, which is followed by ejaculation of semen. In the female, there are contractions (not always subjectively experienced as such) of the wall of the outer third of the vagina. In both genders, the anal sphincter rhythmically contracts.
4. *Resolution:* This phase consists of a sense of muscular relaxation and general well-being. During this phase, males are physiologically refractory to further erection and orgasm for a variable period of time. In contrast, females may be able to respond to additional stimulation almost immediately.

Disorders of sexual response may occur at one or more of these phases. Whenever more than one Sexual Dysfunction is present, all are recorded. No attempt is made in the criteria sets to specify a minimum frequency or range of settings, activities, or types of sexual encounters in which the dysfunction must occur. This judgment must be made by the clinician, taking into account such factors as the age and experience of the individual, frequency and chronicity of the symptom, subjective distress, and effect on other areas of functioning. The words "persistent or recurrent" in the diagnostic criteria indicate the need for such a clinical judgment. If sexual stimulation is inadequate in either focus, intensity, or duration, the diagnosis of Sexual Dysfunction involving excitement or orgasm is not made.

Subtypes

Subtypes are provided to indicate the onset, context, and etiological factors associated with the Sexual Dysfunctions. If multiple Sexual Dysfunctions are present, the appropriate subtypes for each may be noted. These subtypes do not apply to a diagnosis of Sexual Dysfunction Due to a General Medical Condition or Substance-Induced Sexual Dysfunction.

One of the following subtypes may be used to indicate the nature of the onset of the Sexual Dysfunction:

> **Lifelong Type.** This subtype applies if the sexual dysfunction has been present since the onset of sexual functioning.
>
> **Acquired Type.** This subtype applies if the sexual dysfunction develops only after a period of normal functioning.

One of the following subtypes may be used to indicate the context in which the Sexual Dysfunction occurs:

> **Generalized Type.** This subtype applies if the sexual dysfunction is not limited to certain types of stimulation, situations, or partners.

Situational Type. This subtype applies if the sexual dysfunction is limited to certain types of stimulation, situations, or partners. The specific situational pattern of the dysfunction may aid in the differential diagnosis. For example, normal masturbatory function in the presence of impaired partner relational functioning would suggest that a chief complaint of erectile dysfunction is more likely due to an interpersonal or intrapsychic problem rather than attributable to a general medical condition or a substance.

One of the following subtypes may be used to indicate etiological factors associated with the Sexual Dysfunction:

Due to Psychological Factors. This subtype applies when psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the Sexual Dysfunction, and general medical conditions and substances play no role in the etiology of the Sexual Dysfunction.

Due to Combined Factors. This subtype applies when 1) psychological factors are judged to have a role in the onset, severity, exacerbation, or maintenance of the Sexual Dysfunction; and 2) a general medical condition or substance use is also judged to be contributory but is not sufficient to account for the Sexual Dysfunction. If a general medical condition or substance use (including medication side effects) is sufficient to account for the Sexual Dysfunction, Sexual Dysfunction Due to a General Medical Condition (p. 558) and/or Substance-Induced Sexual Dysfunction (p. 562) is diagnosed.

Associated Disorders

Sexual dysfunction may be associated with Mood Disorders and Anxiety Disorders (Obsessive-Compulsive Disorder, Panic Disorder With Agoraphobia, and Specific Phobia).

Specific Culture, Age, and Gender Features

Clinical judgments about the presence of a Sexual Dysfunction should take into account the individual's ethnic, cultural, religious, and social background, which may influence sexual desire, expectations, and attitudes about performance. For example, in some societies, sexual desires on the part of the female are given less relevance (especially when fertility is the primary concern). Aging may be associated with a lowering of sexual interest and functioning (especially in males), but there are wide individual differences in age effects.

Prevalence

There are few systematic epidemiological data regarding the prevalence of the various sexual dysfunctions, and these show extremely wide variability, probably reflecting differences in assessment methods, definitions used, and characteristics of sampled populations. The most comprehensive survey to date, conducted on a representative sample of the U.S. population between ages 18 and 59, suggests the fol-

lowing prevalence estimates for various sexual complaints: 3% for male dyspareunia, 15% for female dyspareunia, 10% for male orgasm problems, 25% for female orgasm problems, 33% for female hypoactive sexual desire, 27% for premature ejaculation, 20% for female arousal problems, and 10% for male erectile difficulties. Male erectile problems also increase in prevalence after age 50. It is unclear whether these sexual complaints would have met diagnostic criteria for a DSM-IV Sexual Disorder. Estimates of prevalence rates for sexual aversion, vaginismus, sexual dysfunctions due to a general medical condition, and substance-induced sexual dysfunctions are not available.

Differential Diagnosis

If the Sexual Dysfunction is judged to be caused exclusively by the physiological effects of a specified general medical condition, the diagnosis is **Sexual Dysfunction Due to a General Medical Condition** (p. 558). This determination is based on history, laboratory findings, or physical examination. If the Sexual Dysfunction is judged to be caused exclusively by the physiological effects of a drug of abuse, a medication, or toxin exposure, the diagnosis is **Substance-Induced Sexual Dysfunction** (see p. 562). The clinician should inquire carefully about the nature and extent of substance use, including medications. Symptoms that occur during or shortly after (i.e., within 4 weeks of) Substance Intoxication or after medication use may be especially indicative of a Substance-Induced Sexual Dysfunction, depending on the type or amount of the substance used or the duration of use.

If the clinician has ascertained that the sexual dysfunction is due to both a general medical condition and substance use, both diagnoses (i.e., Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction) can be given. A primary Sexual Dysfunction diagnosis with the subtype **Due to Combined Factors** is made if a combination of psychological factors and either a general medical condition or a substance is judged to have an etiological role, but no one etiology is sufficient to account for the dysfunction. If the clinician cannot determine the etiological roles of psychological factors, a general medical condition, and substance use, **Sexual Dysfunction Not Otherwise Specified** is diagnosed.

The diagnosis of a Sexual Dysfunction is also not made if the dysfunction is better accounted for by another Axis I disorder (e.g., if diminished sexual desire occurs only in the context of a Major Depressive Episode). However, if the disturbance in sexual functioning antedates the Axis I disorder or is a focus of independent clinical attention, an additional diagnosis of Sexual Dysfunction can also be made. Commonly, if one Sexual Dysfunction is present (e.g., a Sexual Arousal Disorder), additional Sexual Dysfunctions will also be present (e.g., Hypoactive Sexual Desire Disorder). In such cases, all should be diagnosed. A **Personality Disorder** may coexist with a Sexual Dysfunction. In such cases, the Sexual Dysfunction should be recorded on Axis I and the Personality Disorder should be recorded on Axis II. If another clinical condition, such as a **Relational Problem,** is associated with the disturbance in sexual functioning, the Sexual Dysfunction should be diagnosed and the other clinical condition is also noted on Axis I. Occasional problems with sexual desire, arousal, or orgasm that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Sexual Dysfunctions.

Sexual Desire Disorders

302.71 Hypoactive Sexual Desire Disorder

Diagnostic Features

The essential feature of Hypoactive Sexual Desire Disorder is a deficiency or absence of sexual fantasies and desire for sexual activity (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (including medications) or a general medical condition (Criterion C). Low sexual desire may be global and encompass all forms of sexual expression or may be situational and limited to one partner or to a specific sexual activity (e.g., intercourse but not masturbation). There is little motivation to seek stimuli and diminished frustration when deprived of the opportunity for sexual expression. The individual usually does not initiate sexual activity or may only engage in it reluctantly when it is initiated by the partner. Although the frequency of sexual experiences is usually low, pressure from the partner or nonsexual needs (e.g., for physical comfort or intimacy) may increase the frequency of sexual encounters. Because of a lack of normative age- or gender-related data on frequency or degree of sexual desire, the diagnosis must rely on clinical judgment based on the individual's characteristics, the interpersonal determinants, the life context, and the cultural setting. The clinician may need to assess both partners when discrepancies in sexual desire prompt the call for professional attention. Apparent "low desire" in one partner may instead reflect an excessive need for sexual expression by the other partner. Alternatively, both partners may have levels of desire within the normal range but at different ends of the continuum.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Hypoactive Sexual Desire Disorder. (See descriptions on p. 536.)

Associated Features and Disorders

Low sexual interest is frequently associated with problems of sexual arousal or with orgasm difficulties. The deficiency in sexual desire may be the primary dysfunction or may be the consequence of emotional distress induced by disturbances in excitement or orgasm. However, some individuals with low sexual desire retain the capacity for adequate sexual excitement and orgasm in response to sexual stimulation. General medical conditions may have a nonspecific deleterious effect on sexual desire due to weakness, pain, problems with body image, or concerns about survival. Depressive disorders are often associated with low sexual desire, and the onset of depression may precede, co-occur with, or be the consequence of the deficient sexual

desire. Individuals with Hypoactive Sexual Desire Disorder may have difficulties developing stable sexual relationships and may have marital dissatisfaction and disruption.

Course

The age at onset for individuals with Lifelong forms of Hypoactive Sexual Desire Disorder is puberty. More frequently, the disorder develops in adulthood, after a period of adequate sexual interest, in association with psychological distress, stressful life events, or interpersonal difficulties. The loss of sexual desire may be continuous or episodic, depending on psychosocial or relationship factors. An episodic pattern of loss of sexual desire occurs in some individuals in relation to problems with intimacy and commitment.

Differential Diagnosis

Hypoactive Sexual Desire Disorder must be distinguished from **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (see p. 558). This determination is based on history, laboratory findings, or physical examination. Certain general medical conditions such as neurological, hormonal, and metabolic abnormalities may specifically impair the physiological substrates of sexual desire. Abnormalities in total and bioavailable testosterone and prolactin may indicate hormonal disorders responsible for loss of sexual desire. If both Hypoactive Sexual Desire Disorder and a general medical condition are present, but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then Hypoactive Sexual Desire Disorder, Due to Combined Factors, is diagnosed.

In contrast to Hypoactive Sexual Desire Disorder, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a substance (e.g., antihypertensive medication, a drug of abuse) (see p. 562). If both Hypoactive Sexual Desire Disorder and substance use are present, but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Hypoactive Sexual Desire Disorder, Due to Combined Factors, is diagnosed. If the low sexual desire is judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Hypoactive Sexual Desire Disorder may also occur in association with other Sexual Dysfunctions (e.g., Male Erectile Dysfunction). If so, both should be noted. An additional diagnosis of Hypoactive Sexual Desire Disorder is usually not made if the low sexual desire is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder). The additional diagnosis may be appropriate when the low desire predates the Axis I disorder or is a focus of independent clinical attention. **Occasional problems with sexual desire** that are not persistent or recurrent or are not accompanied by marked

distress or interpersonal difficulty are not considered to be Hypoactive Sexual Desire Disorder.

Diagnostic criteria for 302.71 Hypoactive Sexual Desire Disorder

A. Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type:

Lifelong Type
Acquired Type

Specify type:

Generalized Type
Situational Type

Specify:

Due to Psychological Factors
Due to Combined Factors

302.79 Sexual Aversion Disorder

Diagnostic Features

The essential feature of Sexual Aversion Disorder is the aversion to and active avoidance of genital sexual contact with a sexual partner (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) (Criterion C). The individual reports anxiety, fear, or disgust when confronted by a sexual opportunity with a partner. The aversion to genital contact may be focused on a particular aspect of sexual experience (e.g., genital secretions, vaginal penetration). Some individuals experience generalized revulsion to all sexual stimuli, including kissing and touching. The intensity of the individual's reaction when exposed to the aversive stimulus may range from moderate anxiety and lack of pleasure to extreme psychological distress.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Sexual Aversion Disorder. (See descriptions on p. 536.)

Associated Features and Disorders

When confronted with a sexual situation, some individuals with severe Sexual Aversion Disorder may experience Panic Attacks with extreme anxiety, feelings of terror, faintness, nausea, palpitations, dizziness, and breathing difficulties. There may be markedly impaired interpersonal relations (e.g., marital dissatisfaction). Individuals may avoid sexual situations or potential sexual partners by covert strategies (e.g., going to sleep early, traveling, neglecting personal appearance, using substances, and being overinvolved in work, social, or family activities).

Differential Diagnosis

Sexual Aversion Disorder may also occur in association with other Sexual Dysfunctions (e.g., Dyspareunia). If so, both should be noted. An additional diagnosis of Sexual Aversion Disorder is usually not made if the sexual aversion is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder). The additional diagnosis may be made when the aversion predates the Axis I disorder or is a focus of independent clinical attention. Although sexual aversion may technically meet the criteria for **Specific Phobia,** this additional diagnosis is not given. **Occasional sexual aversion** that is not persistent or recurrent or is not accompanied by marked distress or interpersonal difficulty is not considered to be a Sexual Aversion Disorder.

Diagnostic criteria for 302.79 Sexual Aversion Disorder

A. Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction).

Specify type:

Lifelong Type
Acquired Type

Specify type:

Situational Type
Generalized Type

Specify:

Due to Psychological Factors
Due to Combined Factors

Sexual Arousal Disorders

302.72 Female Sexual Arousal Disorder

Diagnostic Features

The essential feature of Female Sexual Arousal Disorder is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement (Criterion A). The arousal response consists of vasocongestion in the pelvis, vaginal lubrication and expansion, and swelling of the external genitalia. The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (including medications) or a general medical condition (Criterion C).

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Female Sexual Arousal Disorder. (See descriptions on p. 536.)

Associated Features and Disorders

Limited evidence suggests that Female Sexual Arousal Disorder is often accompanied by Sexual Desire Disorders and Female Orgasmic Disorder. The individual with Female Sexual Arousal Disorder may have little or no subjective sense of sexual arousal. The disorder may result in painful intercourse, sexual avoidance, and the disturbance of marital or sexual relationships.

Differential Diagnosis

Female Sexual Arousal Disorder must be distinguished from a **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., menopausal or postmenopausal reductions in estrogen levels, atrophic vaginitis, diabetes mellitus, radiotherapy of the pelvis) (see p. 558). Reduced lubrication has also been reported in association with lactation. This determination is based on history, laboratory findings, or physical examination. If both Female Sexual Arousal Disorder and a general medical condition are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological consequences of the general medical condition, then Female Sexual Arousal Disorder, Due to Combined Factors, is diagnosed.

In contrast to Female Sexual Arousal Disorder, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a substance (e.g., reduced lubrication caused by antihypertensives or antihistamines) (see

p. 562). If both Female Sexual Arousal Disorder and substance use are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Female Sexual Arousal Disorder, Due to Combined Factors, is diagnosed.

If the arousal problems are judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Female Sexual Arousal Disorder may also occur in association with other Sexual Dysfunctions (e.g., Female Orgasmic Disorder). If so, both should be noted. An additional diagnosis of Female Sexual Arousal Disorder is usually not made if the sexual arousal problem is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder). The additional diagnosis may be made when the problem with sexual arousal predates the Axis I disorder or is a focus of independent clinical attention. **Occasional problems with sexual arousal** that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Female Sexual Arousal Disorder. A diagnosis of Female Sexual Arousal Disorder is also not appropriate if the problems in arousal are due to sexual stimulation that is not adequate in focus, intensity, and duration.

Diagnostic criteria for 302.72 Female Sexual Arousal Disorder

A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type:

Lifelong Type
Acquired Type

Specify type:

Generalized Type
Situational Type

Specify:

Due to Psychological Factors
Due to Combined Factors

302.72 Male Erectile Disorder

Diagnostic Features

The essential feature of Male Erectile Disorder is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (including medications) or a general medical condition (Criterion C).

There are different patterns of erectile dysfunction. Some individuals will report the inability to obtain any erection from the outset of a sexual experience. Others will complain of first experiencing an adequate erection and then losing tumescence when attempting penetration. Still others will report that they have an erection that is sufficiently firm for penetration but that they then lose tumescence before or during thrusting. Some males may report being able to experience an erection only during self-masturbation or on awakening. Masturbatory erections may be lost as well, but this is not common.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Male Erectile Disorder. (See descriptions on p. 536.)

Associated Features and Disorders

The erectile difficulties in Male Erectile Disorder are frequently associated with sexual anxiety, fear of failure, concerns about sexual performance, and a decreased subjective sense of sexual excitement and pleasure. Erectile dysfunction can disrupt existing marital or sexual relationships and may be the cause of unconsummated marriages and infertility. This disorder may be associated with Hypoactive Sexual Desire Disorder and Premature Ejaculation. Individuals with Mood Disorders and Substance-Related Disorders often report problems with sexual arousal.

Course

The various forms of Male Erectile Disorder follow different courses, and the age at onset varies substantially. The few individuals who have never been able to experience an erection of sufficient quality to complete sexual activity with a partner typically have a chronic, lifelong disorder. Acquired cases may remit spontaneously 15%–30% of the time. Situational cases may be dependent on a type of partner or the intensity or quality of the relationship and are episodic and frequently recurrent.

Differential Diagnosis

Male Erectile Disorder must be distinguished from **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., diabetes mellitus, multiple sclerosis, renal failure, peripheral neuropathy, peripheral vascular disease, spinal cord injury, injury of the autonomic nervous system by surgery or radiation) (see p. 558). This determination is based on history (e.g., impaired erectile functioning during masturbation), laboratory findings, or physical examination. Nocturnal penile tumescence studies can demonstrate whether erections occur during sleep and may be helpful in differentiating primary erectile disorders from Male Erectile Disorder Due to a General Medical Condition. Penile blood pressure, pulse-wave assessments, or duplex ultrasound studies can indicate vasculogenic loss of erectile functioning. Invasive procedures such as intracorporeal pharmacological testing or angiography can assess the presence of arterial flow problems. Cavernosography can evaluate venous competence. If both Male Erectile Disorder and a general medical condition are present but it is judged that the erectile dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then Male Erectile Disorder, Due to Combined Factors, is diagnosed.

A **Substance-Induced Sexual Dysfunction** is distinguished from Male Erectile Disorder by the fact that the sexual dysfunction is judged to be due exclusively to the direct physiological effects of a substance (e.g., antihypertensive medication, antidepressant medication, neuroleptic medication, a drug of abuse) (see p. 562). If both Male Erectile Disorder and substance use are present but it is judged that the erectile dysfunction is not due exclusively to the direct physiological effects of the substance use, then Male Erectile Disorder, Due to Combined Factors, is diagnosed.

If the arousal problems are judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Male Erectile Disorder may also occur in association with other Sexual Dysfunctions (e.g., Premature Ejaculation). If so, both should be noted. An additional diagnosis of Male Erectile Disorder is usually not made if the erectile dysfunction is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder, Obsessive-Compulsive Disorder). The additional diagnosis may be made when the erectile dysfunction predates the Axis I disorder or is a focus of independent clinical attention. **Occasional problems with having erections** that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Male Erectile Disorder. A diagnosis of Male Erectile Disorder is also not appropriate if the erectile dysfunction is due to sexual stimulation that is not adequate in focus, intensity, and duration. Older males may require more stimulation or take longer to achieve a full erection. These physiological changes should not be considered to be Male Erectile Disorder.

Diagnostic criteria for 302.72 Male Erectile Disorder

A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The erectile dysfunction is not better accounted for by another Axis I disorder (other than a Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type:

Lifelong Type
Acquired Type

Specify type:

Generalized Type
Situational Type

Specify:

Due to Psychological Factors
Due to Combined Factors

Orgasmic Disorders

302.73 Female Orgasmic Disorder (*formerly* Inhibited Female Orgasm)

Diagnostic Features

The essential feature of Female Orgasmic Disorder is a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase (Criterion A). Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of Female Orgasmic Disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives. The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (including medications) or a general medical condition (Criterion C).

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors,**

Due to Combined Factors) for Female Orgasmic Disorder. (See descriptions on p. 536.)

Associated Features and Disorders

No association has been found between specific patterns of personality traits or psychopathology and orgasmic dysfunction in females. Female Orgasmic Disorder may affect body image, self-esteem, or relationship satisfaction. According to controlled studies, orgasmic capacity is not correlated with vaginal size or pelvic muscle strength. Although females with spinal cord lesions, removal of the vulva, or vaginal excision and reconstruction have reported reaching orgasm, orgasmic dysfunction is commonly reported in women with these conditions. In general, however, chronic general medical conditions like diabetes or pelvic cancer are more likely to impair the arousal phase of the sexual response, leaving orgasmic capacity relatively intact.

Course

Because orgasmic capacity in females may increase with increasing sexual experience, Female Orgasmic Disorder may be more prevalent in younger women. Most female orgasmic disorders are lifelong rather than acquired. Once a female learns how to reach orgasm, it is uncommon for her to lose that capacity, unless poor sexual communication, relationship conflict, a traumatic experience (e.g., rape), a Mood Disorder, or a general medical condition intervenes. When orgasmic dysfunction occurs only in certain situations, difficulty with sexual desire and arousal are often present in addition to the orgasmic disorder. Many females increase their orgasmic capacity as they experience a wider variety of stimulation and acquire more knowledge about their own bodies.

Differential Diagnosis

Female Orgasmic Disorder must be distinguished from a **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., spinal cord lesion) (see p. 558). This determination is based on history, laboratory findings, or physical examination. If both Female Orgasmic Disorder and a general medical condition are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then Female Orgasmic Disorder, Due to Combined Factors, is diagnosed.

In contrast to Female Orgasmic Disorder, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a substance (e.g., antidepressants, benzodiazepines, neuroleptics, antihypertensives, opioids) (see p. 562). If both Female Orgasmic Disorder and substance use are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Female Orgasmic Disorder, Due to Combined Factors, is diagnosed.

If the sexual dysfunction is judged to be due exclusively to the physiological effects

of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Female Orgasmic Disorder may also occur in association with other Sexual Dysfunctions (e.g., Female Sexual Arousal Disorder). If so, both should be noted. An additional diagnosis of Female Orgasmic Disorder is usually not made if the orgasmic difficulty is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder). This additional diagnosis may be made when the orgasmic difficulty predates the Axis I disorder or is a focus of independent clinical attention. **Occasional orgasmic problems** that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Female Orgasmic Disorder. A diagnosis of Female Orgasmic Disorder is also not appropriate if the problems are due to sexual stimulation that is not adequate in focus, intensity, and duration.

Diagnostic criteria for 302.73 Female Orgasmic Disorder

A. Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of Female Orgasmic Disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The orgasmic dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type:

Lifelong Type
Acquired Type

Specify type:

Generalized Type
Situational Type

Specify:

Due to Psychological Factors
Due to Combined Factors

302.74 Male Orgasmic Disorder (*formerly* Inhibited Male Orgasm)

Diagnostic Features

The essential feature of Male Orgasmic Disorder is a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. In judging whether the orgasm is delayed, the clinician should take into account the person's age and whether the stimulation is adequate in focus, intensity, and duration (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The orgasmic dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (including medications) or a general medical condition (Criterion C). In the most common form of Male Orgasmic Disorder, a male cannot reach orgasm during intercourse, although he can ejaculate from a partner's manual or oral stimulation. Some males with Male Orgasmic Disorder can reach coital orgasm but only after very prolonged and intense noncoital stimulation. Some can ejaculate only from masturbation. An even smaller subgroup have experienced orgasm only at the moment of waking from an erotic dream.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Male Orgasmic Disorder. (See descriptions on p. 536.)

Associated Features and Disorders

Many coitally inorgasmic males describe feeling aroused at the beginning of a sexual encounter but that thrusting gradually becomes a chore rather than a pleasure. A pattern of paraphilic sexual arousal may be present. When a man has hidden his lack of coital orgasms from his wife, the couple may present with infertility of unknown cause. The disorder may result in the disturbance of existing marital or sexual relationships. Males can usually reach orgasm even when vascular or neurological conditions interfere with erectile rigidity. Both the sensation of orgasm and striated muscle contractions at orgasm remain intact in males who lose their prostate and seminal vesicles with radical pelvic cancer surgery. Orgasm also can occur in the absence of emission of semen (e.g., when sympathetic ganglia are damaged by surgery or autonomic neuropathy).

Differential Diagnosis

Male Orgasmic Disorder must be distinguished from a **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g.,

hyperprolactinemia) (see p. 558). This determination is based on history, laboratory findings, or physical examination. Sensory threshold testing may demonstrate reduced sensation in the skin on the penis that is due to a neurological condition (e.g., spinal cord injuries, sensory neuropathies). If both Male Orgasmic Disorder and a general medical condition are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then Male Orgasmic Disorder, Due to Combined Factors, is diagnosed.

In contrast to Male Orgasmic Disorder, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a substance (e.g., alcohol, opioids, antihypertensives, antidepressants, neuroleptics) (see p. 562). If both Male Orgasmic Disorder and substance use are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Male Orgasmic Disorder, Due to Combined Factors, is diagnosed.

If the orgasmic dysfunction is judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Male Orgasmic Disorder may also occur in association with other Sexual Dysfunctions (e.g., Male Erectile Disorder). If so, both should be noted. An additional diagnosis of Male Orgasmic Disorder is usually not made if the orgasmic difficulty is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder). An additional diagnosis may be made when the orgasmic difficulty predates the Axis I disorder or is a focus of independent clinical attention. Several types of Sexual Dysfunction (e.g., ejaculation but without pleasurable orgasm, orgasm that occurs without ejaculation of semen or with seepage of semen rather than propulsive ejaculation) would be diagnosed as **Sexual Dysfunction Not Otherwise Specified** rather than as Male Orgasmic Disorder.

Occasional orgasmic problems that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Male Orgasmic Disorder. As males age, they may require a longer period of stimulation to achieve orgasm. The clinician must also ascertain that there has been sufficient stimulation to attain orgasm.

Diagnostic criteria for 302.74 Male Orgasmic Disorder

A. Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity that the clinician, taking into account the person's age, judges to be adequate in focus, intensity, and duration.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The orgasmic dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type:

Lifelong Type
Acquired Type

Specify type:

Generalized Type
Situational Type

Specify:

Due to Psychological Factors
Due to Combined Factors

302.75 Premature Ejaculation

Diagnostic Features

The essential feature of Premature Ejaculation is the persistent or recurrent onset of orgasm and ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it (Criterion A). The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity. The majority of males with this disorder can delay orgasm during self-masturbation for a considerably longer time than during coitus. Partners' estimates of the duration of time from the beginning of sexual activity until ejaculation as well as their judgment of whether Premature Ejaculation is a problem can be quite disparate. The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids) (Criterion C).

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Premature Ejaculation. (See descriptions on p. 536.)

Associated Features and Disorders

Like other Sexual Dysfunctions, Premature Ejaculation may create tension in a relationship. Some unmarried males hesitate to begin dating new partners out of fear of embarrassment from the disorder. This can contribute to social isolation.

Course

A majority of young males learn to delay orgasm with sexual experience and aging, but some continue to ejaculate prematurely and may seek help for the disorder. Some males are able to delay ejaculation in a long-term relationship but experience a recurrence of Premature Ejaculation when they have a new partner. Typically, Premature Ejaculation is seen in young men and is present from their first attempts at intercourse. However, some males lose the ability to delay orgasm after a period of adequate function. When onset occurs after a period of adequate sexual function, the context is often a decreased frequency of sexual activity, intense performance anxiety with a new partner, or loss of ejaculatory control related to difficulty achieving or maintaining erections. Some males who have stopped regular use of alcohol may develop Premature Ejaculation because they relied on their drinking to delay orgasm instead of learning behavioral strategies.

Differential Diagnosis

Premature Ejaculation should be distinguished from **erectile dysfunction related to the development of a general medical condition** (see p. 558). Some individuals with erectile dysfunction may omit their usual strategies for delaying orgasm. Others require prolonged noncoital stimulation to develop a degree of erection sufficient for intromission. In such individuals, sexual arousal may be so high that ejaculation occurs immediately. **Occasional problems with premature ejaculation** that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty do not qualify for the diagnosis of Premature Ejaculation. The clinician should also take into account the individual's age, overall sexual experience, recent sexual activity, and the novelty of the partner. When problems with Premature Ejaculation are due exclusively to substance use (e.g., Opioid Withdrawal), a **Substance-Induced Sexual Dysfunction** can be diagnosed (see p. 562).

Diagnostic criteria for 302.75 Premature Ejaculation

A. Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids).

Specify type:

Lifelong Type
Acquired Type

Specify type:

Generalized Type
Situational Type

Specify:

Due to Psychological Factors
Due to Combined Factors

Sexual Pain Disorders

302.76 Dyspareunia (Not Due to a General Medical Condition)

Diagnostic Features

The essential feature of Dyspareunia is genital pain that is associated with sexual intercourse (Criterion A). Although it is most commonly experienced during coitus, it may also occur before or after intercourse. The disorder can occur in both males and females. In females, the pain may be described as superficial during intromission or as deep during penile thrusting. The intensity of the symptoms may range from mild discomfort to sharp pain. The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The disturbance is not caused exclusively by Vaginismus or lack of lubrication, is not better accounted for by another Axis I disorder (except for another Sexual Dysfunction), and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (Criterion C).

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Dyspareunia. (See descriptions on p. 536.)

Associated Features and Disorders

Dyspareunia is rarely a chief complaint in mental health settings. Individuals with Dyspareunia typically seek treatment in general medical settings. The physical examination for individuals with this disorder typically does not demonstrate genital abnormalities. The repeated experience of genital pain during coitus may result in the avoidance of sexual experience, disrupting existing sexual relationships or limiting the development of new sexual relationships.

Course

The limited amount of information available suggests that the course of Dyspareunia tends to be chronic.

Differential Diagnosis

Dyspareunia must be distinguished from **Sexual Dysfunction Due to a General Medical Condition** (see p. 558). The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., insufficient vaginal lubrication; pelvic pathology such as vaginal or urinary tract infections, vaginal scar tissue, endometriosis, or adhesions; postmenopausal vaginal atrophy; temporary estrogen deprivation during lactation; urinary tract irritation or infection; or gastrointestinal conditions). This determination is based on history, laboratory findings, or physical examination. If both Dyspareunia and a general medical condition are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then a diagnosis of Dyspareunia, Due to Combined Factors, is made.

In contrast to Dyspareunia, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a substance (see p. 562). Painful orgasm has been reported with fluphenazine, thioridazine, and amoxapine. If both Dyspareunia and substance use are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Dyspareunia, Due to Combined Factors, is diagnosed.

If the sexual pain is judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Dyspareunia is not diagnosed if it is caused exclusively by Vaginismus or a lack of lubrication. An additional diagnosis of Dyspareunia is usually not made if the sexual dysfunction is better accounted for by **another Axis I disorder** (e.g., Somatization

Disorder). The additional diagnosis may be made when the orgasmic difficulty predates the Axis I disorder or is a focus of independent clinical attention. Dyspareunia can also occur in association with other Sexual Dysfunctions (except Vaginismus), and if criteria for both are met, both should be coded. **Occasional pain associated with sexual intercourse** that is not persistent or recurrent or is not accompanied by marked distress or interpersonal difficulty is not considered to be Dyspareunia.

Diagnostic criteria for 302.76 Dyspareunia

A. Recurrent or persistent genital pain associated with sexual intercourse in either a male or a female.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The disturbance is not caused exclusively by Vaginismus or lack of lubrication, is not better accounted for by another Axis I disorder (except another Sexual Dysfunction), and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type:

Lifelong Type
Acquired Type

Specify type:

Generalized Type
Situational Type

Specify:

Due to Psychological Factors
Due to Combined Factors

306.51 Vaginismus (Not Due to a General Medical Condition)

Diagnostic Features

The essential feature of Vaginismus is the recurrent or persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration with penis, finger, tampon, or speculum is attempted (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The disturbance is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a general medical condition (Criterion C). In some females, even the anticipation of vaginal insertion may result in muscle spasm. The contraction may range from mild, inducing some tightness and discomfort, to severe, preventing penetration.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Vaginismus. (See descriptions on p. 536.)

Associated Features and Disorders

Sexual responses (e.g., desire, pleasure, orgasmic capacity) may not be impaired unless penetration is attempted or anticipated. The physical obstruction due to muscle contraction usually prevents coitus. The condition, therefore, can limit the development of sexual relationships and disrupt existing relationships. Cases of unconsummated marriages and infertility have been found to be associated with this condition. The diagnosis is often made during routine gynecological examinations when response to the pelvic examination results in the readily observed contraction of the vaginal outlet. In some cases, the intensity of the contraction may be so severe or prolonged as to cause pain. However, Vaginismus occurs in some women during sexual activity but not during a gynecological examination. The disorder is more often found in younger than in older females, in females with negative attitudes toward sex, and in females who have a history of being sexually abused or traumatized.

Course

Lifelong Vaginismus usually has an abrupt onset, first manifest during initial attempts at sexual penetration by a partner or during the first gynecological examination. Once the disorder is established, the course is usually chronic unless ameliorated by treatment. Acquired Vaginismus also may occur suddenly in response to a sexual trauma or a general medical condition.

Differential Diagnosis

Vaginismus must be distinguished from a **Sexual Dysfunction Due to a General Medical Condition** (see p. 558). The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., endometriosis or vaginal infection). This determination is based on history, laboratory findings, or physical examination. Vaginismus may remain as a residual problem after resolution of the general medical condition. If both Vaginismus and a general medical condition are present but it is judged that the vaginal spasms are not due exclusively to the direct physiological effects of the general medical condition, a diagnosis of Vaginismus, Due to Combined Factors, is made.

Vaginismus may also occur in association with other Sexual Dysfunctions (e.g., Hypoactive Sexual Desire Disorder). If so, both should be noted. Although pain associated with sexual intercourse may occur with Vaginismus, an additional diagnosis of **Dyspareunia** is not given. An additional diagnosis of Vaginismus is usually not made if the vaginal spasms are better accounted for by **another Axis I condition** (e.g., Somatization Disorder). The additional diagnosis may be made when the vaginal spasms predate the Axis I disorder or are a focus of independent clinical attention.

Diagnostic criteria for 306.51 Vaginismus

A. Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The disturbance is not better accounted for by another Axis I disorder (e.g., Somatization Disorder) and is not due exclusively to the direct physiological effects of a general medical condition.

Specify type:

Lifelong Type
Acquired Type

Specify type:

Generalized Type
Situational Type

Specify:

Due to Psychological Factors
Due to Combined Factors

Sexual Dysfunction Due to a General Medical Condition

Diagnostic Features

The essential feature of Sexual Dysfunction Due to a General Medical Condition is the presence of clinically significant sexual dysfunction that is judged to be due exclusively to the direct physiological effects of a general medical condition. The sexual dysfunction can involve pain associated with intercourse, hypoactive sexual desire, male erectile dysfunction, or other forms of sexual dysfunction (e.g., Orgasmic Disorders) and must cause marked distress or interpersonal difficulty (Criterion A). There must be evidence from the history, physical examination, or laboratory findings that the dysfunction is fully explained by the direct physiological effects of a general medical condition (Criterion B). The disturbance is not better accounted for by another mental disorder (e.g., Major Depressive Disorder) (Criterion C).

In determining whether the sexual dysfunction is exclusively due to a general medical condition, the clinician must first establish the presence of a general medical condition. Further, the clinician must establish that the sexual dysfunction is etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the sexual dysfunction and the general medical condition is etio-

logical, several considerations provide some guidance in this area. One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the sexual dysfunction. A second consideration is the presence of features that are atypical of a primary Sexual Dysfunction (e.g., atypical age at onset or course). Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of the sexual dysfunction can provide a useful context in the assessment of a particular situation. In addition, the clinician must also judge that the disturbance is not better accounted for by a primary Sexual Dysfunction, a Substance-Induced Sexual Dysfunction, or another primary mental disorder (e.g., Major Depressive Disorder). These determinations are explained in greater detail in the "Mental Disorders Due to a General Medical Condition" section (p. 181).

In contrast, a Sexual Dysfunction diagnosis with the subtype "Due to Combined Factors" is made if a combination of psychological factors and either a general medical condition or a substance is judged to have an etiological role, but no one etiology is sufficient to account for the dysfunction.

Subtypes

The diagnostic code and term for a Sexual Dysfunction Due to a General Medical Condition is selected based on the predominant Sexual Dysfunction. The terms listed below should be used instead of the overall rubric "Sexual Dysfunction Due to a General Medical Condition."

625.8 Female Hypoactive Sexual Desire Disorder Due to . . . ***[Indicate the General Medical Condition].*** This term is used if, in a female, deficient or absent sexual desire is the predominant feature.

608.89 Male Hypoactive Sexual Desire Disorder Due to . . . ***[Indicate the General Medical Condition].*** This term is used if, in a male, deficient or absent sexual desire is the predominant feature.

607.84 Male Erectile Disorder Due to . . . ***[Indicate the General Medical Condition].*** This term is used if male erectile dysfunction is the predominant feature.

625.0 Female Dyspareunia Due to . . . ***[Indicate the General Medical Condition].*** This term is used if, in a female, pain associated with intercourse is the predominant feature.

608.89 Male Dyspareunia Due to . . . ***[Indicate the General Medical Condition].*** This term is used if, in a male, pain associated with intercourse is the predominant feature.

625.8 Other Female Sexual Dysfunction Due to . . . ***[Indicate the General Medical Condition].*** This term is used if, in a female, some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates.

608.89 Other Male Sexual Dysfunction Due to . . . ***[Indicate the General Medical Condition].*** This term is used if, in a male, some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates.

Recording Procedures

In recording the diagnosis of Sexual Dysfunction Due to a General Medical Condition, the clinician should note both the specific phenomenology of the dysfunction (from the list above) and the identified general medical condition judged to be causing the dysfunction on Axis I (e.g., 607.84 Male Erectile Disorder Due to Diabetes Mellitus). The ICD-9-CM code for the general medical condition is also noted on Axis III (e.g., 250.0 diabetes mellitus). (See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.)

Associated General Medical Conditions

A variety of general medical conditions can cause sexual dysfunction, including neurological conditions (e.g., multiple sclerosis, spinal cord lesions, neuropathy, temporal lobe lesions), endocrine conditions (e.g., diabetes mellitus, hypothyroidism, hyper- and hypoadrenocorticism, hyperprolactinemia, hypogonadal states, pituitary dysfunction), vascular conditions, and genitourinary conditions (e.g., testicular disease, Peyronie's disease, urethral infections, postprostatectomy complications, genital injury or infection, atrophic vaginitis, infections of the vagina and external genitalia, postsurgical complications such as episiotomy scars, shortened vagina, cystitis, endometriosis, uterine prolapse, pelvic infections, neoplasms, oophorectomy without hormone replacement, and side effects of cancer treatments [surgical, radiation, chemotherapy]). Current clinical experience suggests that Sexual Dysfunction Due to a General Medical Condition is usually generalized. The associated physical examination findings, laboratory findings, and patterns of prevalence or onset reflect the etiological general medical condition.

Differential Diagnosis

Sexual Dysfunction Due to a General Medical Condition is diagnosed only if the sexual dysfunction is fully explained by the direct effects of a general medical condition. If psychological factors also play a role in the onset, severity, exacerbation, or maintenance of a sexual dysfunction, the diagnosis is the **primary Sexual Dysfunction** (with the subtype **Due to Combined Factors**). In determining whether the sexual dysfunction is primary or exclusively due to the direct effects of a general medical condition, a comprehensive psychosexual and medical history is the most important component of the evaluation. For males, tests such as nocturnal penile tumescence, vascular studies, and injection of tissue activators may be helpful in the assessment. Careful gynecological examination is important in making these determinations in women, especially in assessing Sexual Pain Disorders in females. Neurological evaluation and endocrine assessment may be helpful in both men and women.

If there is evidence of recent or prolonged substance use (including medications), withdrawal from a substance, or exposure to a toxin, and that the sexual dysfunction is fully explained by the direct effects of the substance, a **Substance-Induced Sexual Dysfunction** should be considered. The clinician should inquire carefully about the nature and extent of substance use, including medications. Symptoms that occur during or shortly after (i.e., within 4 weeks of) Substance Intoxication or after medication

use may be especially indicative of a Substance-Induced Sexual Dysfunction, depending on the type or amount of the substance used or the duration of use. If the clinician has ascertained that the sexual dysfunction is due to both a general medical condition and substance use, both diagnoses (i.e., Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction) can be given.

Hypoactive sexual desire, arousal dysfunction, and, to a lesser extent, orgasmic dysfunction can also occur as symptoms of **Major Depressive Disorder.** In Major Depressive Disorder, no specific and direct causative pathophysiological mechanisms associated with a general medical condition can be demonstrated. Sexual Dysfunction Due to a General Medical Condition must be distinguished from the **diminished sexual interest and functioning that may accompany aging.**

Diagnostic criteria for Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]*

A. Clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty predominates in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings that the sexual dysfunction is fully explained by the direct physiological effects of a general medical condition.

C. The disturbance is not better accounted for by another mental disorder (e.g., Major Depressive Disorder).

Select code and term based on the predominant sexual dysfunction:

625.8 Female Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition]:* if deficient or absent sexual desire is the predominant feature

608.89 Male Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition]:* if deficient or absent sexual desire is the predominant feature

607.84 Male Erectile Disorder Due to . . . *[Indicate the General Medical Condition]:* if male erectile dysfunction is the predominant feature

625.0 Female Dyspareunia Due to . . . *[Indicate the General Medical Condition]:* if pain associated with intercourse is the predominant feature

608.89 Male Dyspareunia Due to . . . *[Indicate the General Medical Condition]:* if pain associated with intercourse is the predominant feature

625.8 Other Female Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]:* if some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates

608.89 Other Male Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]:* if some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates

Coding note: Include the name of the general medical condition on Axis I, e.g., 607.84 Male Erectile Disorder Due to Diabetes Mellitus; also code the general medical condition on Axis III (see Appendix G for codes).

Substance-Induced Sexual Dysfunction

Diagnostic Features

The essential feature of Substance-Induced Sexual Dysfunction is a clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty (Criterion A). Depending on the substance involved, the dysfunction may involve impaired desire, impaired arousal, impaired orgasm, or sexual pain. The dysfunction is judged to be fully explained by the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure) (Criterion B). The disturbance must not be better accounted for by a Sexual Dysfunction that is not substance induced (Criterion C). This diagnosis should be made instead of a diagnosis of Substance Intoxication only when the sexual symptoms are in excess of those usually associated with the intoxication syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention. For a more detailed discussion of Substance-Related Disorders, see p. 191.

A Substance-Induced Sexual Dysfunction is distinguished from a primary Sexual Dysfunction by considering onset and course. For drugs of abuse, there must be evidence of intoxication from the history, physical examination, or laboratory findings. Substance-Induced Sexual Dysfunctions arise only in association with intoxication, whereas primary Sexual Dysfunctions may precede the onset of substance use or occur during times of sustained abstinence from the substance. Factors suggesting that the dysfunction is better accounted for by a primary Sexual Dysfunction include persistence of the dysfunction for a substantial period of time (i.e., a month or more) after the end of Substance Intoxication; the development of a dysfunction that is substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or a history of prior recurrent primary Sexual Dysfunctions.

Specifiers

The following specifiers for Substance-Induced Sexual Dysfunction are selected based on the predominant sexual dysfunction. Although the clinical presentation of the sexual dysfunction may resemble one of the specific primary Sexual Dysfunctions, the full criteria for one of these disorders need not be met.

With Impaired Desire. This specifier is used if deficient or absent sexual desire is the predominant feature.

With Impaired Arousal. This specifier is used if impaired sexual arousal (e.g., erectile dysfunction, impaired lubrication) is the predominant feature.

With Impaired Orgasm. This specifier is used if impaired orgasm is the predominant feature.

With Sexual Pain. This specifier is used if pain associated with intercourse is the predominant feature.

Substance-Induced Sexual Dysfunctions usually have their onset during Substance Intoxication, and this may be indicated by noting **With Onset During Intoxication.**

Recording Procedures

The name of the Substance-Induced Sexual Dysfunction begins with the specific substance (e.g., alcohol, fluoxetine) that is presumed to be causing the sexual dysfunction. The diagnostic code is selected from the listing of classes of substances provided in the criteria set. For substances that do not fit into any of the classes (e.g., fluoxetine), the code for "Other Substance" should be used. In addition, for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code on Axis I (see Appendix G). The name of the disorder is followed by the specification of predominant symptom presentation (e.g., 292.89 Cocaine-Induced Sexual Dysfunction, With Impaired Arousal). When more than one substance is judged to play a significant role in the development of the sexual dysfunction, each should be listed separately (e.g., 291.89 Alcohol-Induced Sexual Dysfunction, With Impaired Arousal; 292.89 Fluoxetine-Induced Sexual Dysfunction, With Impaired Orgasm). If a substance is judged to be the etiological factor, but the specific substance or class of substances is unknown, the category 292.89 Unknown Substance–Induced Sexual Dysfunction may be used.

Specific Substances

Sexual Dysfunctions can occur in association with **intoxication** with the following classes of substances: alcohol; amphetamine and related substances; cocaine; opioids; sedatives, hypnotics, and anxiolytics; and other or unknown substances. Acute intoxication with or chronic Abuse of or Dependence on substances of abuse has been reported to decrease sexual interest and cause arousal problems in both sexes. A decrease in sexual interest, arousal disorders, and orgasmic disorders may also be caused by prescribed medications including antihypertensives, histamine H_2 receptor antagonists, antidepressants (especially selective serotonin reuptake inhibitors), neuroleptics, anxiolytics, anabolic steroids, and antiepileptics. Painful orgasm has been reported with fluphenazine, thioridazine, and amoxapine. Priapism has been reported with use of chlorpromazine, trazodone, and clozapine and following penile injections of papaverine or prostaglandin. Medications such as antihypertensive agents or anabolic steroids may also promote depressed or irritable mood in addition to the sexual dysfunction, and an additional diagnosis of Substance-Induced Mood Disorder may be warranted. Current clinical experience strongly suggests that Substance-Induced Sexual Dysfunction is usually generalized (i.e., not limited to certain types of stimulation, situations, or partners).

Differential Diagnosis

Substance-induced sexual dysfunctions are most likely to occur during **Substance Intoxication.** The diagnosis of the substance-specific Intoxication will usually suffice to categorize the symptom presentation. A diagnosis of Substance-Induced Sexual Dysfunction should be made instead of a diagnosis of Substance Intoxication only when the dysfunction is judged to be in excess of that usually associated with the intoxication syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention. If psychological factors also play a role in the onset, severity,

exacerbation, or maintenance of a sexual dysfunction, the diagnosis is the primary Sexual Dysfunction (with the subtype Due to Combined Factors).

A Substance-Induced Sexual Dysfunction is distinguished from a **primary Sexual Dysfunction** by the fact that the symptoms are judged to be fully explained by the direct effects of a substance (see p. 562).

A Substance-Induced Sexual Dysfunction due to a prescribed treatment for a mental disorder or general medical condition must have its onset while the person is receiving the medication (e.g., antihypertensive medication). Once the treatment is discontinued, the sexual dysfunction will remit within days to several weeks (depending on the half-life of the substance). If the sexual dysfunction persists, other causes for the dysfunction should be considered. Side effects of prescribed medications that affect sexual function may lead individuals to be noncompliant with the medication regimen if they value sexual performance over the benefits of the medication.

Because individuals with general medical conditions often take medications for those conditions, the clinician must consider the possibility that the sexual dysfunction is caused by the physiological consequences of the general medical condition rather than the medication, in which case **Sexual Dysfunction Due to a General Medical Condition** is diagnosed. The history often provides the primary basis for such a judgment. At times, a change in the treatment for the general medical condition (e.g., medication substitution or discontinuation) may be needed to determine empirically for that person whether the medication is the causative agent. If the clinician has ascertained that the dysfunction is due to both a general medical condition and substance use, both diagnoses (i.e., Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction) are given. When there is insufficient evidence to determine whether the Sexual Dysfunction is due to a substance (including a medication) or to a general medical condition or is primary (i.e., not due to either a substance or a general medical condition), **Sexual Dysfunction Not Otherwise Specified** would be indicated.

Diagnostic criteria for Substance-Induced Sexual Dysfunction

A. Clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty predominates in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings that the sexual dysfunction is fully explained by substance use as manifested by either (1) or (2):

   (1) the symptoms in Criterion A developed during, or within a month of, Substance Intoxication
   (2) medication use is etiologically related to the disturbance

C. The disturbance is not better accounted for by a Sexual Dysfunction that is not substance induced. Evidence that the symptoms are better accounted for by a Sexual Dysfunction that is not substance induced might include the following: the symptoms precede the onset of the substance use or dependence (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of intoxication, or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence that suggests the existence of an independent non-substance-induced Sexual Dysfunction (e.g., a history of recurrent non-substance-related episodes).

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication only when the sexual dysfunction is in excess of that usually associated with the intoxication syndrome and when the dysfunction is sufficiently severe to warrant independent clinical attention.

Code [Specific Substance]–Induced Sexual Dysfunction:

(291.89 Alcohol; 292.89 Amphetamine [or Amphetamine-Like Substance]; 292.89 Cocaine; 292.89 Opioid; 292.89 Sedative, Hypnotic, or Anxiolytic; 292.89 Other [or Unknown] Substance)

Specify if:

With Impaired Desire
With Impaired Arousal
With Impaired Orgasm
With Sexual Pain

Specify if:

With Onset During Intoxication: if the criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome

302.70 Sexual Dysfunction Not Otherwise Specified

This category includes sexual dysfunctions that do not meet criteria for any specific Sexual Dysfunction. Examples include

1. No (or substantially diminished) subjective erotic feelings despite otherwise-normal arousal and orgasm
2. Situations in which the clinician has concluded that a sexual dysfunction is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced

Paraphilias

Diagnostic Features

The essential features of a Paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months (Criterion A). For some individuals, paraphilic fantasies or stimuli are obligatory for erotic arousal and are always included in sexual activity. In other cases, the paraphilic preferences occur only episodically (e.g., perhaps during periods of stress), whereas at other times the person is able to function sexually without paraphilic fantasies or stimuli. For Pedophilia, Voyeurism, Exhibitionism, and Frotteurism, the diagnosis is made if the person has acted on these urges or the urges or sexual fantasies cause marked distress or interpersonal difficulty. For Sexual Sadism, the diagnosis is made if the person has acted on these urges with a nonconsenting person or the urges, sexual fantasies, or behaviors cause marked distress or interpersonal difficulty. For the remaining Paraphilias, the diagnosis is made if the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B).

Paraphilic imagery may be acted out with a nonconsenting partner in a way that may be injurious to the partner (as in Sexual Sadism or Pedophilia). The individual may be subject to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal sex acts, and individuals with Exhibitionism, Pedophilia, and Voyeurism make up the majority of apprehended sex offenders. In some situations, acting out the paraphilic imagery may lead to self-injury (as in Sexual Masochism). Social and sexual relationships may suffer if others find the unusual sexual behavior shameful or repugnant or if the individual's sexual partner refuses to cooperate in the unusual sexual preferences. In some instances, the unusual behavior (e.g., exhibitionistic acts or the collection of fetish objects) may become the major sexual activity in the individual's life. These individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with sexual partners or society.

The Paraphilias described here are conditions that have been specifically identified by previous classifications. They include Exhibitionism (exposure of genitals), Fetishism (use of nonliving objects), Frotteurism (touching and rubbing against a nonconsenting person), Pedophilia (focus on prepubescent children), Sexual Masochism (receiving humiliation or suffering), Sexual Sadism (inflicting humiliation or suffer-

ing), Transvestic Fetishism (cross-dressing), and Voyeurism (observing sexual activity). A residual category, Paraphilia Not Otherwise Specified, includes other Paraphilias that are less frequently encountered. Not uncommonly, individuals have more than one Paraphilia.

Recording Procedures

The individual Paraphilias are differentiated based on the characteristic paraphilic focus. However, if the individual's sexual preferences meet criteria for more than one Paraphilia, all should be diagnosed. The diagnostic code and terms are as follows: 302.4 Exhibitionism, 302.81 Fetishism, 302.89 Frotteurism, 302.2 Pedophilia, 302.83 Sexual Masochism, 302.84 Sexual Sadism, 302.3 Transvestic Fetishism, 302.82 Voyeurism, and 302.9 Paraphilia Not Otherwise Specified.

Associated Features and Disorders

Associated descriptive features and mental disorders. The preferred stimulus, even within a particular Paraphilia, may be highly specific. Individuals who do not have a consenting partner with whom their fantasies can be acted out may purchase the services of prostitutes or may act out their fantasies with unwilling victims. Individuals with a Paraphilia may select an occupation or develop a hobby or volunteer work that brings them into contact with the desired stimulus (e.g., selling women's shoes or lingerie [Fetishism], working with children [Pedophilia], or driving an ambulance [Sexual Sadism]). They may selectively view, read, purchase, or collect photographs, films, and textual depictions that focus on their preferred type of paraphilic stimulus. Many individuals with these disorders assert that the behavior causes them no distress and that their only problem is social dysfunction as a result of the reaction of others to their behavior. Others report extreme guilt, shame, and depression at having to engage in an unusual sexual activity that is socially unacceptable or that they regard as immoral. There is often impairment in the capacity for reciprocal, affectionate sexual activity, and Sexual Dysfunctions may be present. Personality disturbances are also frequent and may be severe enough to warrant a diagnosis of a Personality Disorder. Symptoms of depression may develop in individuals with Paraphilias and may be accompanied by an increase in the frequency and intensity of the paraphilic behavior.

Associated laboratory findings. Penile plethysmography has been used in research settings to assess various Paraphilias by measuring an individual's sexual arousal in response to visual and auditory stimuli. The reliability and validity of this procedure in clinical assessment have not been well established, and clinical experience suggests that subjects can simulate response by manipulating mental images.

Associated general medical conditions. Frequent, unprotected sex may result in infection with, or transmission of, a sexually transmitted disease. Sadistic or masochistic behaviors may lead to injuries ranging in extent from minor to life threatening.

Specific Culture and Gender Features

The diagnosis of Paraphilias across cultures or religions is complicated by the fact that what is considered deviant in one cultural setting may be more acceptable in another setting. Except for Sexual Masochism, where the sex ratio is estimated to be 20 males for each female, the other Paraphilias are almost never diagnosed in females, although some cases have been reported.

Prevalence

Although Paraphilias are rarely diagnosed in general clinical facilities, the large commercial market in paraphilic pornography and paraphernalia suggests that its prevalence in the community is likely to be higher. The most common presenting problems in clinics that specialize in the treatment of Paraphilias are Pedophilia, Voyeurism, and Exhibitionism. Sexual Masochism and Sexual Sadism are much less commonly seen. Approximately one-half of the individuals with Paraphilias seen clinically are married.

Course

Certain of the fantasies and behaviors associated with Paraphilias may begin in childhood or early adolescence but become better defined and elaborated during adolescence and early adulthood. Elaboration and revision of paraphilic fantasies may continue over the lifetime of the individual. By definition, the fantasies and urges associated with these disorders are recurrent. Many individuals report that the fantasies are always present but that there are periods of time when the frequency of the fantasies and intensity of the urges vary substantially. The disorders tend to be chronic and lifelong, but both the fantasies and the behaviors often diminish with advancing age in adults. The behaviors may increase in response to psychosocial stressors, in relation to other mental disorders, or with increased opportunity to engage in the Paraphilia.

Differential Diagnosis

A Paraphilia must be distinguished from the **nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement** in individuals without a Paraphilia. Fantasies, behaviors, or objects are paraphilic only when they lead to clinically significant distress or impairment (e.g., are obligatory, result in sexual dysfunction, require participation of nonconsenting individuals, lead to legal complications, interfere with social relationships).

In **Mental Retardation, Dementia, Personality Change Due to a General Medical Condition, Substance Intoxication,** a **Manic Episode**, or **Schizophrenia,** there may be a decrease in judgment, social skills, or impulse control that, in rare instances, leads to unusual sexual behavior. This can be distinguished from a Paraphilia by the fact that the unusual sexual behavior is not the individual's preferred or obligatory pattern, the sexual symptoms occur exclusively during the course of these mental disorders, and the unusual sexual acts tend to be isolated rather than recurrent and usually have a later age at onset.

The individual Paraphilias can be distinguished based on differences in the characteristic paraphilic focus. However, if the individual's sexual preferences meet criteria for more than one Paraphilia, all can be diagnosed. **Exhibitionism** must be distinguished from **public urination,** which is sometimes offered as an explanation for the behavior. **Fetishism** and **Transvestic Fetishism** both often involve articles of feminine clothing. In Fetishism, the focus of sexual arousal is on the article of clothing itself (e.g., panties), whereas in Transvestic Fetishism the sexual arousal comes from the act of cross-dressing. Cross-dressing, which is present in **Transvestic Fetishism,** may also be present in **Sexual Masochism.** In Sexual Masochism, it is the humiliation of being forced to cross-dress, not the garments themselves, that is sexually exciting.

Cross-dressing may be associated with gender dysphoria. If some gender dysphoria is present but the full criteria for Gender Identity Disorder are not met, the diagnosis is **Transvestic Fetishism, With Gender Dysphoria.** Individuals should receive the additional diagnosis of **Gender Identity Disorder** if their presentation meets the full criteria for Gender Identity Disorder.

302.4 Exhibitionism

The paraphilic focus in Exhibitionism involves the exposure of one's genitals to a stranger. Sometimes the individual masturbates while exposing himself (or while fantasizing exposing himself). If the person acts on these urges, there is generally no attempt at further sexual activity with the stranger. In some cases, the individual is aware of a desire to surprise or shock the observer. In other cases, the individual has the sexually arousing fantasy that the observer will become sexually aroused. The onset usually occurs before age 18 years, although it can begin at a later age. Few arrests are made in the older age groups, which may suggest that the condition becomes less severe after age 40 years.

Diagnostic criteria for 302.4 Exhibitionism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one's genitals to an unsuspecting stranger.

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.81 Fetishism

The paraphilic focus in Fetishism involves the use of nonliving objects (the "fetish"). Among the more common fetish objects are women's underpants, bras, stockings, shoes, boots, or other wearing apparel. The person with Fetishism frequently masturbates while holding, rubbing, or smelling the fetish object or may ask the sexual partner to wear the object during their sexual encounters. Usually the fetish is required or strongly preferred for sexual excitement, and in its absence there may be erectile dys-

function in males. This Paraphilia is not diagnosed when the fetishes are limited to articles of female clothing used in cross-dressing, as in Transvestic Fetishism, or when the object is genitally stimulating because it has been designed for that purpose (e.g., a vibrator). Usually the Paraphilia begins by adolescence, although the fetish may have been endowed with special significance earlier in childhood. Once established, Fetishism tends to be chronic.

Diagnostic criteria for 302.81 Fetishism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects (e.g., female undergarments).

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The fetish objects are not limited to articles of female clothing used in cross-dressing (as in Transvestic Fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator).

302.89 Frotteurism

The paraphilic focus of Frotteurism involves touching and rubbing against a nonconsenting person. The behavior usually occurs in crowded places from which the individual can more easily escape arrest (e.g., on busy sidewalks or in public transportation vehicles). He rubs his genitals against the victim's thighs and buttocks or fondles her genitalia or breasts with his hands. While doing this he usually fantasizes an exclusive, caring relationship with the victim. However, he recognizes that to avoid possible prosecution, he must escape detection after touching his victim. Usually the paraphilia begins by adolescence. Most acts of frottage occur when the person is ages 15–25 years, after which there is a gradual decline in frequency.

Diagnostic criteria for 302.89 Frotteurism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person.

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.2 Pedophilia

The paraphilic focus of Pedophilia involves sexual activity with a prepubescent child (generally age 13 years or younger). The individual with Pedophilia must be age 16 years or older and at least 5 years older than the child. For individuals in late adolescence with Pedophilia, no precise age difference is specified, and clinical judgment must be used; both the sexual maturity of the child and the age difference must be taken into account. Individuals with Pedophilia generally report an attraction to children of a particular age range. Some individuals prefer males, others females, and some are aroused by both males and females. Those attracted to females usually prefer 8- to 10-year-olds, whereas those attracted to males usually prefer slightly older children. Pedophilia involving female victims is reported more often than Pedophilia involving male victims. Some individuals with Pedophilia are sexually attracted only to children (Exclusive Type), whereas others are sometimes attracted to adults (Nonexclusive Type). Individuals with Pedophilia who act on their urges with children may limit their activity to undressing the child and looking, exposing themselves, masturbating in the presence of the child, or gentle touching and fondling of the child. Others, however, perform fellatio or cunnilingus on the child or penetrate the child's vagina, mouth, or anus with their fingers, foreign objects, or penis and use varying degrees of force to do so. These activities are commonly explained with excuses or rationalizations that they have "educational value" for the child, that the child derives "sexual pleasure" from them, or that the child was "sexually provocative"—themes that are also common in pedophilic pornography. Because of the egosyntonic nature of Pedophilia, many individuals with pedophilic fantasies, urges, or behaviors do not experience significant distress. It is important to understand that experiencing distress about having the fantasies, urges, or behaviors is not necessary for a diagnosis of Pedophilia. Individuals who have a pedophilic arousal pattern and act on these fantasies or urges with a child qualify for the diagnosis of Pedophilia.

Individuals may limit their activities to their own children, stepchildren, or relatives or may victimize children outside their families. Some individuals with Pedophilia threaten the child to prevent disclosure. Others, particularly those who frequently victimize children, develop complicated techniques for obtaining access to children, which may include winning the trust of a child's mother, marrying a woman with an attractive child, trading children with other individuals with Pedophilia, or, in rare instances, taking in foster children from nonindustrialized countries or abducting children from strangers. Except in cases in which the disorder is associated with Sexual Sadism, the person may be attentive to the child's needs in order to gain the child's affection, interest, and loyalty and to prevent the child from reporting the sexual activity. The disorder usually begins in adolescence, although some individuals with Pedophilia report that they did not become aroused by children until middle age. The frequency of pedophilic behavior often fluctuates with psychosocial stress. The course is usually chronic, especially in those attracted to males. The recidivism rate for individuals with Pedophilia involving a preference for males is roughly twice that for those who prefer females.

Diagnostic criteria for 302.2 Pedophilia

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

Specify if:

Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both

Specify if:

Limited to Incest

Specify type:

Exclusive Type (attracted only to children)
Nonexclusive Type

302.83 Sexual Masochism

The paraphilic focus of Sexual Masochism involves the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer. Some individuals are bothered by their masochistic fantasies, which may be invoked during sexual intercourse or masturbation but not otherwise acted on. In such cases, the masochistic fantasies usually involve being raped while being held or bound by others so that there is no possibility of escape. Others act on the masochistic sexual urges by themselves (e.g., binding themselves, sticking themselves with pins, shocking themselves electrically, or self-mutilation) or with a partner. Masochistic acts that may be sought with a partner include restraint (physical bondage), blindfolding (sensory bondage), paddling, spanking, whipping, beating, electrical shocks, cutting, "pinning and piercing" (infibulation), and humiliation (e.g., being urinated or defecated on, being forced to crawl and bark like a dog, or being subjected to verbal abuse). Forced cross-dressing may be sought for its humiliating associations. The individual may have a desire to be treated as a helpless infant and clothed in diapers ("infantilism"). One particularly dangerous form of Sexual Masochism, called "hypoxyphilia," involves sexual arousal by oxygen deprivation obtained by means of chest compression, noose, ligature, plastic bag, mask, or chemical (often a volatile nitrite that produces a temporary decrease

in brain oxygenation by peripheral vasodilation). Oxygen-depriving activities may be engaged in alone or with a partner. Because of equipment malfunction, errors in the placement of the noose or ligature, or other mistakes, accidental deaths sometimes occur. Data from the United States, England, Australia, and Canada indicate that one to two hypoxyphilia-caused deaths per million population are detected and reported each year. Some males with Sexual Masochism also have Fetishism, Transvestic Fetishism, or Sexual Sadism. Masochistic sexual fantasies are likely to have been present in childhood. The age at which masochistic activities with partners first begins is variable, but is commonly by early adulthood. Sexual Masochism is usually chronic, and the person tends to repeat the same masochistic act. Some individuals with Sexual Masochism may engage in masochistic acts for many years without increasing the potential injuriousness of their acts. Others, however, increase the severity of the masochistic acts over time or during periods of stress, which may eventually result in injury or even death.

Diagnostic criteria for 302.83 Sexual Masochism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

302.84 Sexual Sadism

The paraphilic focus of Sexual Sadism involves acts (real, not simulated) in which the individual derives sexual excitement from the psychological or physical suffering (including humiliation) of the victim. Some individuals with this Paraphilia are bothered by their sadistic fantasies, which may be invoked during sexual activity but not otherwise acted on; in such cases the sadistic fantasies usually involve having complete control over the victim, who is terrified by anticipation of the impending sadistic act. Others act on the sadistic sexual urges with a consenting partner (who may have Sexual Masochism) who willingly suffers pain or humiliation. Still others with Sexual Sadism act on their sadistic sexual urges with nonconsenting victims. In all of these cases, it is the suffering of the victim that is sexually arousing. Sadistic fantasies or acts may involve activities that indicate the dominance of the person over the victim (e.g., forcing the victim to crawl or keeping the victim in a cage). They may also involve restraint, blindfolding, paddling, spanking, whipping, pinching, beating, burning, electrical shocks, rape, cutting, stabbing, strangulation, torture, mutilation, or killing. Sadistic sexual fantasies are likely to have been present in childhood. The age at onset of sadistic activities is variable, but is commonly by early adulthood. Sexual Sadism is usually chronic. When Sexual Sadism is practiced with nonconsenting partners, the activity is likely to be repeated until the person with Sexual Sadism is apprehended. Some individuals with Sexual Sadism may engage in sadistic acts for

many years without a need to increase the potential for inflicting serious physical damage. Usually, however, the severity of the sadistic acts increases over time. When Sexual Sadism is severe, and especially when it is associated with Antisocial Personality Disorder, individuals with Sexual Sadism may seriously injure or kill their victims.

Diagnostic criteria for 302.84 Sexual Sadism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

B. The person has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.3 Transvestic Fetishism

The paraphilic focus of Transvestic Fetishism involves cross-dressing by a male in women's attire. In many or most cases, sexual arousal is produced by the accompanying thought or image of the person as a female (referred to as "autogynephilia"). These images can range from being a woman with female genitalia to that of a view of the self fully dressed as a woman with no real attention to genitalia. Women's garments are arousing primarily as symbols of the individual's femininity, not as fetishes with specific objective properties (e.g., objects made of rubber). Usually the male with Transvestic Fetishism keeps a collection of female clothes that he intermittently uses to cross-dress. This disorder has been described only in heterosexual males. Transvestic Fetishism is not diagnosed when cross-dressing occurs exclusively during the course of Gender Identity Disorder. Transvestic phenomena range from occasional solitary wearing of female clothes to extensive involvement in a transvestic subculture. Some males wear a single item of women's apparel (e.g., underwear or hosiery) under their masculine attire. Other males with Transvestic Fetishism dress entirely as females and wear makeup. The degree to which the cross-dressed individual successfully appears to be a female varies, depending on mannerisms, body habitus, and cross-dressing skill. When not cross-dressed, the male with Transvestic Fetishism is usually unremarkably masculine. Although his basic preference is heterosexual, he tends to have few sexual partners and may have engaged in occasional homosexual acts. An associated feature may be the presence of Sexual Masochism. The disorder typically begins with cross-dressing in childhood or early adolescence. In many cases, the cross-dressing is not done in public until adulthood. The initial experience may involve partial or total cross-dressing; partial cross-dressing often progresses to complete cross-dressing. A favored article of clothing may become erotic in itself and may be used habitually, first in masturbation and later in intercourse. In some individuals, the motivation for cross-dressing may change over time, temporarily or permanently, with sexual arousal in response to the cross-dressing diminishing or disappearing. In such instances, the cross-dressing becomes an antidote to anxiety or depression or

contributes to a sense of peace and calm. In other individuals, gender dysphoria may emerge, especially under situational stress with or without symptoms of depression. For a small number of individuals, the gender dysphoria becomes a fixed part of the clinical picture and is accompanied by the desire to dress and live permanently as a female and to seek hormonal or surgical reassignment. Individuals with Transvestic Fetishism often seek treatment when gender dysphoria emerges. The subtype With Gender Dysphoria is provided to allow the clinician to note the presence of gender dysphoria as part of Transvestic Fetishism.

Diagnostic criteria for 302.3 Transvestic Fetishism

A. Over a period of at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With Gender Dysphoria: if the person has persistent discomfort with gender role or identity

302.82 Voyeurism

The paraphilic focus of Voyeurism involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. The act of looking ("peeping") is for the purpose of achieving sexual excitement, and generally no sexual activity with the observed person is sought. Orgasm, usually produced by masturbation, may occur during the voyeuristic activity or later in response to the memory of what the person has witnessed. Often these individuals have the fantasy of having a sexual experience with the observed person, but in reality this rarely occurs. In its severe form, peeping constitutes the exclusive form of sexual activity. The onset of voyeuristic behavior is usually before age 15 years. The course tends to be chronic.

Diagnostic criteria for 302.82 Voyeurism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.9 Paraphilia Not Otherwise Specified

This category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

Gender Identity Disorders

Gender Identity Disorder

Diagnostic Features

There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis. There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex (Criterion A). This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B). The diagnosis is not made if the individual has a concurrent physical intersex condition (e.g., partial androgen insensitivity syndrome or congenital adrenal hyperplasia) (Criterion C). To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D).

In boys, the cross-gender identification is manifested by a marked preoccupation with traditionally feminine activities. They may have a preference for dressing in girls' or women's clothes or may improvise such items from available materials when genuine articles are unavailable. Towels, aprons, and scarves are often used to represent long hair or skirts. There is a strong attraction for the stereotypical games and pastimes of girls. They particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. Stereotypical female-type dolls, such as Barbie, are often their favorite toys, and girls are their preferred playmates. When playing "house," these boys role-play female figures, most commonly "mother roles," and often are quite preoccupied with female fantasy figures. They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks or other nonaggressive but stereotypical boys' toys. They may express a wish to be a girl and assert that they will grow up to be a woman. They may insist on sitting to urinate and pretend not to have a penis by pushing it in between their legs. More rarely, boys with Gender Identity Disorder may state that they find their penis or testes disgusting, that they want to remove them, or that they have, or wish to have, a vagina.

Girls with Gender Identity Disorder display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire. Some

may refuse to attend school or social events where such clothes may be required. They prefer boys' clothing and short hair, are often misidentified by strangers as boys, and may ask to be called by a boy's name. Their fantasy heroes are most often powerful male figures, such as Batman or Superman. These girls prefer boys as playmates, with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games. They show little interest in dolls or any form of feminine dress-up or role-play activity. A girl with this disorder may occasionally refuse to urinate in a sitting position. She may claim that she has or will grow a penis and may not want to grow breasts or to menstruate. She may assert that she will grow up to be a man. Such girls typically reveal marked cross-gender identification in role-playing, dreams, and fantasies.

Adults with Gender Identity Disorder are preoccupied with their wish to live as a member of the other sex. This preoccupation may be manifested as an intense desire to adopt the social role of the other sex or to acquire the physical appearance of the other sex through hormonal or surgical manipulation. Adults with this disorder are uncomfortable being regarded by others as, or functioning in society as, a member of their designated sex. To varying degrees, they adopt the behavior, dress, and mannerisms of the other sex. In private, these individuals may spend much time cross-dressed and working on the appearance of being the other sex. Many attempt to pass in public as the other sex. With cross-dressing and hormonal treatment (and for males, electrolysis), many individuals with this disorder may pass convincingly as the other sex. The sexual activity of these individuals with same-sex partners is generally constrained by the preference that their partners neither see nor touch their genitals. For some males who present later in life (often following marriage), the individual's sexual activity with a woman is accompanied by the fantasy of being lesbian lovers or that his partner is a man and he is a woman.

In adolescents, the clinical features may resemble either those of children or those of adults, depending on the individual's developmental level, and the criteria should be applied accordingly. In a younger adolescent, it may be more difficult to arrive at an accurate diagnosis because of the adolescent's guardedness. This may be increased if the adolescent feels ambivalent about cross-gender identification or feels that it is unacceptable to the family. The adolescent may be referred because the parents or teachers are concerned about social isolation or peer teasing and rejection. In such circumstances, the diagnosis should be reserved for those adolescents who appear quite cross-gender identified in their dress and who engage in behaviors that suggest significant cross-gender identification (e.g., shaving legs in males). Clarifying the diagnosis in children and adolescents may require monitoring over an extended period of time.

Distress or disability in individuals with Gender Identity Disorder is manifested differently across the life cycle. In young children, distress is manifested by the stated unhappiness about their assigned sex. Preoccupation with cross-gender wishes often interferes with ordinary activities. In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress, and some children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex. In adolescents and adults, preoccupation with cross-gender wishes often interferes with ordinary activities. Relationship difficulties are common, and functioning at school or at work may be impaired.